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THE POST-TRAUMA EXPERIENCE AND THE THERAPEUTIC VALUE OF WORKING WITH POST-TRAUMATIC NIGHTMARES

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A thesis
submitted to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Masters of Education

Winnipeg, Manitoba

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Abstract

Various researchers have reported on the common occurance of post-traumatic nightmares after any traumatic event. Some authors even state that they work with the nightmare in therapy with survivors. However, few authors describe what method to use or how to work with the traumatic nightmare. This study began with the hypothesis that post-traumatic nightmares are valuable in the healing process and that working with them would facilitate healing. The goal was to present a manual of dream work that would describe in detail, various methods of working with the post-traumatic nightmare.

This study examined the human reactions to traumas, post-traumatic nightmares and methods of working with nightmares and concluded that: (a) Nightmares fulfill an adaptive function to traumatic situations; (b) The post-traumatic nightmare is therapeutically valuable in the healing process for trauma survivors and nightmare work can be used as a tool to aid in this process; (c) Post-traumatic nightmares can be worked with in the counselling environment; and, (d) There are dreamwork methods that can be easily learned and incorporated by counsellors of trauma survivors.

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INTRODUCTION

Nightmares, which have fascinated us for centuries because they are so frightening, so primitive, and so unlike waking experience (Hartmann, 1984) have been given many conflicting explanations. According to Freud (1965), nightmares are the result of masochistic wish-fulfillment. When the nature of the wish is extremely unacceptable and yet the force of the desire threatens to overcome the repression, a nightmare occurs and the conflict is interrupted by the dreamer's waking up. Hall (1966) viewed nightmares as self-punishment for disregarding certain tenets of the conscience and yielding to temptation. The nightmare is the price the dreamer pays for this transgression. La-Berge (1985), sees nightmares as the unhappy result of unhealthy reactions. Anxiety arises when we encounter a fear-provoking situation against which our habitual patterns of behavior are useless. If a person experiences a recurring anxiety dream, what he or she obviously needs is a new approach for coping with the situation represented by the dream. This may not be easy to find, since the dream results from unresolved conflicts that the dreamer does not want to face in waking life. Faraday (1974) suggests that Gestalt therapy, with its topdog and underdog theory, offers an adequate model of nightmares. The nightmare occurs because the underdog has defied the topdog or the topdog has denied the underdog during the day. During

the night they struggle to regain control in a "fight to the death", which accounts for the feeling of dread and terror in the nightmare itself. Jung (1974), would suggest that nightmares contain images that represent the "shadow" or that part of the self one considers unacceptable which is searching for acceptance.

Research in the area of frequent and recurring nightmares has focused mainly on the possible relationship between nightmares and psychopathology with mixed findings. Several studies have observed greater psychopathology in nightmare sufferers (Hersen, 1972; Kales,Soldatos, Caldwell, Charney, Kales, Markel & Cadieux, 1980 and Hartmann, 1984); although no one form of psychopathology has been exclusively associated with nightmares. Hartmann (1984) explains that the pathology of frequent nightmare sufferers results from the fact that they possess "thin" cognitive boundaries, which increases the likelihood that ordinary concerns will spill into their dreams. Other studies have not observed a relationship between psychopathology and nightmares (Belicki & Belicki, 1982; Belicki, 1985 and Hartmann, Russ, Oldfield, Sivan and Cooper,1987). For example, Hartmann, et al (1987) have observed that individuals with frequent nightmares tend to be creative and artistic.

In several studies it has been demonstrated that frequent nightmares are a relatively prevalent experience in the adult population (Belicki & Belicki, 1982; Halliday, 1987; Hersen, 1972; van der Kolk, Bliz, Burr, Sherry &

Hartmann, 1984). Halliday (1987) states that nightmares are sufficiently frequent that the clinician/counsellor/therapist can expect to encounter them in the ordinary pursuit of his or her practice and can expect some clients to specifically enter therapy with the request of eliminating or understanding nightmares.

One type of recurring nightmare, the post-traumatic nightmare, will be the focus of this paper. Post-traumatic nightmares are common (Hartman, 1984; van der Kolk, 1985 and van der Kolk, et al, 1984). These nightmares occur to some extent after any trauma - accident, violent crime, natural or human-made disasters as flood, earthquake or war and they can be observed in children, adolescents and adults. The essence of the traumatic experience is that it is a sudden, unexpected, terrifying event. Rycroft (1979), suggests that the person experiencing the traumatic event is a passive victim and in no way an active participating agent. In an adult, post-traumatic nightmares "require not only an external trauma, but an external trauma occurring in a situation of vulnerability..." (Hartmann, 1984, p. 212).

Traumatic nightmares consist of actual repetitions of the preceding traumatic experience. "The content is repetitive, more like a memory than like a dream or fantasy, a memory that is played over and over" (Hartmann, 1984, p. 185). Thus, post-traumatic nightmares differ from ordinary nightmares, from night terrors and from dreams in that they repeat in sleep a negative experience that has happened in

life.

> Whereas patients may complain that ordinary nightmares "make no sense", and may include fantastic elements, traumatic nightmares are often very realistic, repetitive, and faith-ful to the actual memory of the traumatic event. (Halliday, 1987, p. 503)

Statement of Problem

This study will examine the nature of trauma, post-traumatic stress disorder and the role of traumatic nightmares in the reaction and recovery from traumatic experiences. As well, a discussion of the counselling implications and techniques for working with the traumatic nightmare will be presented. In this paper the writer will address the following questions:

1) What is the human reaction to trauma? What is the healing process after a traumatic event? Are there any reactions such as shock, anger, or depression that are universally experienced when people encounter an aversive life event? Do persons who encounter life crises that are as different as experiencing criminal victimization and loss of a spouse show any similarities in response? Do people progress through an orderly sequence of stages as they attempt to cope with the outcome? Is it true that with time, people accept or recover from their crisis and move on to the next stage in their lives? Finally, what ***is*** successful adjustment to a traumatic life event? The large and increasing numbers of victims of trauma and people suffering from symptoms following trauma, requires further

clarification of these issues (Esper,1986; Halliday, 1982; Kramer & Kinney, 1988; Krupnick, 1980; Randle, 1985 and Saldana, 1986).

2) What is the post-traumatic nightmare? How is the post-traumatic nightmare different from other nightmares? Why and how is the post-traumatic nightmare important in the healing process after a trauma? How can the counsellor work with the traumatic nightmare to aid in the healing process after a trauma?

For the most part, this study will focus on trauma that is initiated from outside events (like violence, war, or disaster) and the individuals reactions to these traumatic situations.

Background and Significance of the Problem

The study of trauma is a broad field that includes investigations of personal loss (Cooperman & Schafer, 1983; Millen & Roll, 1985 and Stern, 1985), illness and accident (Kellerman, 1979; Leopold & Dillon, 1963 and Shuchter & Zisook, 1984), victimization such as rape (Atkeson, et al 1982; Burgess & Holmstrom, 1974 & 1979; Ellis, et al 1981 & 1982; McCahill, et al, 1979; Resick, et al, 1981; Sutherland & Scherl, 1970 and Symonds, 1976), incest (Beck & van der Kolk, 1987; Blake-White & Kline, 1985 and Ellenson, 1985), sexual abuse (Garfield, 1987 and Mannarino & Cohen, 1986), violence (Carmen, et al, 1984; Esper, 1986; Saldana, 1986; Sales, et al, 1984; Siegel, 1984 and Terr, 1982; 1983),

kidnapping (Terr, 1982; 1983) and hijacking (Siegel, 1984). Survivors of natural or human-made disaster (Lifton & Olsen, 1976; Lindy, et al, 1983; McCaughey, 1986; Seroka, et al, 1986; Tittchener & Knapp, 1976 and Winnik, 1968), World War I and II (Archibald, et al, 1962 and Lavie, et al, 1979), Vietnam War (Amen, 1985; Brett & Ostroff, 1985; DeFazio, et al, 1975; Eichelman, 1985; Fairbank & Keane, 1982; Glover, 1984; Kramer & Kinney, 1988; Krammer, et al, 1982; Kramer, et al; 1984 & 1987; Langley, 1982; Paul, 1985; Shatan, 1973; Starker & Jolin, 1982, van der Kolk, 1985; van der Kolk, et al, 1984; William, 1983 and Wilmer, 1982 & 1986), nuclear war (Sargent, 1984), the Holocaust (Epstein, 1982; Krell, 1985; Trautman, 1964) and prisoners of war (Boehnlein, et al, 1985; Goldstein, et al, 1987; Kinzie, et al, 1984; Kluznik, et al, 1986; and Mollica, et al, 1987) have been studied as well. Much can be learned about the human response to stress and the healing process from this varied body of literature.

In order to further examine reactions to trauma, it will first be helpful to briefly explore some definitions of trauma.

Furst (1978) explains that psychic trauma refers to the specific type of breakdown which occurs when, within a short period of time, the mind is presented with a quantity of stimulus too great to be dealt with or assimilated in the usual way. Trauma may also be defined as "a condition of illness resulting from physical injury or insult and/or emotional shock" (p. 96).

For Moses (1978), the term trauma applies to a:

> sudden disruptive experience which pierces, violates or rents the stimulus barrier, leads to a degree of paralysis and immobilization and deprives the ego suddenly of its autonomous function, brings about regressive phenomena and severe inhibitions. A traumatic reaction takes place in response to an inner or outer stimulus, perceived as overwhelming the ego functions; ... it has a characteristic recovery pattern which includes attempts at restitution. (p. 354)

Also, it is important to differentiate unpleasant experiences in general from traumata in particular, and to differentiate responses to the threat of trauma from the reactions to the trauma itself.

For the purposes of this study trauma is defined as a condition resulting from a startling or shocking experience that has a lasting effect on mental life. Thus, trauma is sudden and totally disruptive. The trauma can come from without or within (from bodily illness or from world event) from any locus, and can be of any magnitude. Reactions to traumatic events involve feelings of helplessness in the face of overwhelming danger. Thus, the traumatic state has been described as "paralyzing, immobilizing, or rendering to a state of helplessness, ranging from numbness to an emotional storm in affect and behavior. This includes the disorganization of feelings, thoughts, and behavior..." (Furst, 1969, p.96)

It is the writers opinion that the reactions to trauma should not be defined as an illness or disorder and that the individual's reactions to traumatic events should be seen as

a natural and necessary attempt at adjustment to life threatening situations.

One theory that tries to explain readjustment to life threatening events is the biological or physio-psychological theory. In this theory, the ideal or healthy state is one of homeostasis. The trauma upsets this state, and is therefore pathogenetic. The ideal goal of treatment is the re-establishment of the equilibrium. However, in reviewing the literature on trauma, it becomes evident that the situation after the trauma must not necessarily be a return to homeostasis, and its disturbance is not automatically pathological (Esper, 1986). In fact, many writers suggest that the life of a victim of a trauma will never return to the way it was before the traumatic event (Brull, 1969; Burgess & Holstrom, 1974; Saldana, 1986; Silver & Wortman, 1980 and Resick, et al, 1981). It is also evident now that the "crisis" period following a traumatic event appears longer and more pervasive than has been previously indicated in the literature (Sales, et al, 1984 and Silver & Wortman, 1980).

As mentioned earlier, post-traumatic nightmares are a common occurrance following traumatic experiences. Frightening dreams have been repeatedly and vividly described by all populations of trauma victims. Recently, pathological response to stressful events has been designated "Post Traumatic Stress Disorder" (PTSD) and included in the American Psychiatric Association's Diagnostic and Statistical

Manual (DSM-III-R).

Kramer & Kinney (1988) note that of the four components of PTSD as defined in the DSM-III, it is the re-experiencing phenomenon that is both reported to be a symptom central to the syndrome as well as being peculiar to this disorder. The nightmare is probably the most frequent of these re-experiencing phenomena. According to Kramer & Kinney (1988) and Kramer, et al, (1987) then, traumatic nightmares might be the hallmark of PTSD. Thus, it is important for this study, a study of post-traumatic healing process, to include an examination of PTSD.

While many authors reporting the human reaction to trauma and PTSD note that nightmares are central symptoms to the response to trauma, few suggest or explain how to work with the nightmare as part of their treatment process. Therefore, this study will focus on the post-traumatic nightmare and central to this focus will be an examination of procedures for working with the post-traumatic nightmare in order to aid in the healing process.

Mattoon (1978) and Rycroft (1979) state that traumatic nightmares cannot be interpreted since the traumatic events they repetitiously reproduce are invasions and intrusions upon the victims psychological continuity and are in no sense creations of their own imagination or envisaged consequences of their own actions. Since they are undisturbed by analysis they need not be explored in therapy. Similarily, Hartmann (1984) says as the client "works through" her/his trauma in

waking life the nightmare will fade naturally and La-Berge (1985), states that it maybe difficult to fix the nightmare without fixing the personality that gave rise to it. Many other writers suggest that the nightmare is a dream and therefore can be interpreted and can be a valuable tool in treatment of traumatic experiences (Bishay, 1985; Cautella, 1968; Eichelman, 1985; Millen & Roll, 1985; Miller, Stevenson, & Soper, 1982; Miller & Dipilato, 1983; Morris, 1985; Reed, 1984; Terr, 1982; Titchener & Knapp, 1976; Ullman, 1984; and Wallace & Parad, 1980).

It is the writer's belief that post-traumatic nightmares can be worked with in the counselling environment and that they are therapeutically valuable in the healing process. An individual can learn from the traumatic experience and from the nightmare produced by the trauma. Also, the individual can learn to develop a sense of control with regard to the trauma and the nightmares and experience personal growth as opposed to accepting feelings of helplessness and powerlessness in the face of terrifying nightmares.

Presentation of the Study

This thesis will consist of four chapters starting with a discussion of the human reactions to trauma, a description of post-traumatic nightmares, ways to use post-traumatic nightmares when counselling victims of trauma and conclude with a discussion of the material presented. The chapters will be organized as follows:

Chapter I: The Post-traumatic Experience.

This chapter will present an overview of the human reactions to traumatic events. Specific areas to be examined include acute and long-term reactions, normal and pathological responses, PTSD, treatment approaches and stages of the healing process, and research literature on victims of traumatic events.

Chapter II: Post-traumatic Nightmares.

This chapter will present an overview of the literature on post-traumatic nightmares. Comparisons will be made between ordinary nightmares, night terrors and post-traumatic nightmares. As well there will be a brief discussion of the current sleep and dream research.

Chapter III: Working with Post-traumatic Nightmares in Counselling.

This chapter will explore the therapeutic value of working with dreams and nightmares. A discussion of individual and group methods of working with post-traumatic nightmares in counselling will be presented.

Chapter IV: Summary and Discussion.

Chapter IV will discuss the information gathered, draw conclusions and make recommendations in the areas studied.

CHAPTER 1

THE POST-TRAUMATIC EXPERIENCE

This chapter will review the human response to traumatic situations. The evidence supporting a universal response to traumatic situations, stages of recovery and successful adjustment will be examined. Included in this examination will be an inspection of the acute and long-term responses and a discussion of post-traumatic stress disorder. Research literature on victims of different types of catastrophes will be presented in order to identify similarities as well as differences in reactions to these situations. This chapter will conclude with a very brief overview of treatment approaches in the recovery process.

As mentioned in the introduction, trauma is defined as a condition resulting from a startling or shocking experience that has a lasting effect on mental life. The Random House Dictionary (1988) defines trauma as follows:

1. Pathology- (a) a bodily injury produced by violence or any thermal chemical, or other extrinsic agent. (b) the condition resulting from the injury
2. Psychiatry- a startling experience that has a lasting effect on mental life; shock. Greek- trauma=wound.

Lindemann (1944) defined trauma as the sudden uncontrollable severance of affective ties and Krystal (1978) stated that in the acute traumatic state one stands alone and abandoned by all sources of feelings of security.

Figley (1985) uses the concept of trauma to represent:

> an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience which shattered the survivor's sense of invulnerablility to harm. (p. xvii)

A catastrophe, the situational prerequisite for the emergence of a trauma, is defined by Figley as "an extraordinary event or series of events which is sudden, overwhelming, and often dangerous, either to one's self or significant other(s)" (p. xvii). Another word for the precipitating event is the traumatic stressor (Rynearson, 1986). Rynearson defines a traumatic stressor as an aversive stimulus that moblizes so much painful affect that psychologic adaptive mechanisms are overwhelmed. A trauma, then, is a wound or injury and the emotional reaction following a castastrophic event.

A trauma can also be differientiated from a crisis which originates from the Greek word Krisis meaning a turning point or decision. Crisis refers to "a stage in a sequence of events at which the trend for all future events is determined; turning point... a condition of instability... leading to a decisive change." (Random House Dictionary, 1988). A crisis period may be associated with a trauma but is not identical to, nor is it necessarily the result of, a catastrophic event.

The focus of this paper will be on post-traumatic stress reactions rather than traumatic stress reactions. That is, rather than the individual's reaction *during* a catastrophe, attention will be given to the "set of conscious and

unconscous behaviors and emotions associated with dealing with the *memories* of the stressors of the catastrophe and immediately afterwards" (Figley, 1985, p. xix).

Post-Traumatic Stress Response

Universal Response

Some studies (Burgess & Holmstrom, 1974, 1979; Figley, 1985 and Horowitz, 1976,1985) suggest that individuals react to trauma in predictable ways, but is there a specific emotional reaction such as shock, anger or depression that is universally experienced by individuals who encounter adversive life-threatening events? Shontz (1965) would answer this positively, proposing that once the inevitability of a traumatic situation is realized, virtually all individuals experience shock. In contrast, Klinger (1975) states that people initially respond to a trauma with invigoration, anger and aggression. Depression is well documented as a reaction to certain traumas (Frears & Schneider, 1981; Garber & Seligman, 1980 and Kubler-Ross, 1969, 1974), although different predictions are made about when it will occur. Some of the reported initial reactions to traumatic stressors include shock, fear, invigoration, anger, depression, rage, intense feelings of vulnerabiliy, aggression and anxiety (Figley, 1985; van der Kolk, 1987, Burgess & Holmstrom, 1974, Horowitz, 1976).

A review of the literature indicates that while many

authors report that the survivors of particular catastrophes initially react with certain emotions, these authors fail to give statistical evidence of this fact. Often evidence is suggested from the author's clinical observations and/or reports of other practictioner's observations (while this is valuable knowledge, it may be biased and/or inaccurate and unsystematic). For example, the author may be recording only those incidents that support her/his theories and hypothesis and ignoring other data. In systematically collecting and recording the actual emotional reactions of survivors, the evidence is more likely to be factual. As well, many of the reports from the victims are obtained retrospectively, where the victims are asked to report their initial feelings some time after the trauma has occurred. However, Tyhurst (1951) conducted immediate observations of individuals who were involved in community disasters such as fires and floods. He observed three distinct reactions. Many individuals reacted with shock, and showed behaviors characteristic of shock-"stunned or "bewildered" reaction, "definite restriction of the field of attention", "lack of awareness of any subjective feeling of emotion" and "automatic or reflex behavior". A second group of survivors were "cool and collected" during the acute situation. A third group responded with feelings of overwhelming confusion and reactions such as "paralyzing anxiety" or "hysterical crying".(p. 766)

Burgess & Holmstrom (1974, 1976, 1979) also found more

than one type of response to trauma. They describe two types of reactions they observed in the rape victims they studied. They called these two styles the Controlled Style and the Expressive Style. The controlled style consisted of feelings being masked or hidden and a calm, composed, or subdued affect was observed and the expressive style involved feelings being expressed through such behavior as crying, sobbing, smiling, restlessness, and tenseness.

Horowitz's (1976) intrusive and denial phases correspond with Burgess & Holmstrom's (1976) controlled and expressive styles. Horowitz believes in general stress response tendencies which take two seemingly opposite forms. One (intrusive phase) is manifested by intrusive and repetitive thoughts, emotions and behaviors. The other (denial phase) involves ideational denial, emotional numbing and behavioral constriction (p.4). The findings presented by Titchener & Kapp (1976) are similar to those reported by Horowitz (1976). They state that during the first days after a disaster, the survivors reported problems ranging from emotional outbursts to the simple inablity to feel anything. Similarily, Bard & Sangrey (1980, 1986) report some individuals react to victimization with disbelief and numbness and others react with disorganization and confusion.

Other investigators have also investigated victims shortly after a trauma. They have mentioned that shock, disbelief, agitation and incoherence are sometimes experienced, but feelings of numbness or disbelief were

second in frequency; fear was the most common emotion (Burgess & Holmstrom, 1974 and Sutherland & Scherl, 1970). Also, Kilpatrick, Veronen, Resick (1979) report that fear was the most common initial emotion reported by the rape victims they studied. They suggest that fear and anxiety are classically conditioned responses to rape in that 96% of victims reported being scared, 96% felt worried and 92% actually felt terrified. Thus, these victims may have expressed their reactions in different styles (e.g.: expressive or controlled) but their initial emotion was that of fear.

Janoff-Bulman & Frieze (1983) suggest a variety of common emotional reactions to criminal victimization may be observed including shock, confusion, helplessness, anxiety, fear and depression. Additional emotional reactions immediately following an assault, that result from being faced with a life threatening situation are: fear, humiliation, shock, self-blame, dismay, disbelief, and revenge (Klinic Crisis Training Manual, 1988).

Others report that denial is the initial reaction of the terminally ill patient to hearing of their own impending death. (Kubler-Ross, 1969, 1974) and is the first response to criminal victimization (Neiderbach, 1986). Likewise, Horowitz (1976) suggests that individuals repond to trauma first with an outcry "oh, no - it can't be!" and Golan (1978) reports what she calls the disaster syndrome which involves absence of emotion, lack of response to present stimuli,

inhibition of outward activity, and docility. Persons are described as "stunned", "dazed", "shocked". Further, though, Golan states that first reactions range from dazed bewilderment, disbelief and a sense of catastrophic loss to profound relief and gratitude for having passed through the worst and still being alive.

Variable results also emerge when we explore whether individuals respond initially to catastrophes with invigoration or anger. Klinger (1975) maintains that a person initially responds to obstacles or theatened loss with increased vigor and anger. However, studies of rape victims find that anger is a relatively rare reaction immediately after an assault (Meyer & Taylor, 1986 and Notman & Nadelson, 1976). It should be noted that although an anger reaction was found to be rare (in only 20% of the victims), anger is present for some victims.

There is a fair amount of consensus that individuals experience feelings of sadness or depression soon after losing a spouse or a child (Clayton, Desmarais, Winokur, 1968 and Lindemann, 1944). However feelings of depression are uncommon initial reactions to rape (Burgess & Holmstrom, 1976) again, fear and anxiety appear to be the most prevailing response (Sutherland & Scherl, 1970).

The reports of human reactions to traumatic life events presented above give some evidence to conclude that there is no one universal predictable response to a trauma. Silver & Wortman (1980) have also examined the literature pertaining

to the reported initial reactions to traumatic stressors -- shock, fear, invigoration, anger, depression, and anxiety. They conclude that taken as a whole, the empirical evidence suggests that there is little consensus concerning how individuals react to undesirable life events. Rather than one universal emotional response to trauma, then, there appears to be a continuous range of reactions which Burgess & Holmstrom (1974) label the Rape Trauma Syndrome, Figley (1985) names the Post-Traumatic Stress Reaction and Horowitz (1976) calls Stress Response Syndromes. Others have labelled these reactions the Survivor Syndrome (Krystal, 1968,1971,1978), the Disaster Syndrome (Golan, 1978), Post-Sexual Abuse Syndrome (Briere, 1984) the Victim Trauma Syndrome (Neiderbach, 1986) and Post-traumatic Stress Disorder (DSM-III, 1980, DSM-III-R, 1987).

Themes and Patterns of Responses

While no universal emotional response exists after a trauma, there are patterns or themes that we can expect and the human response to sudden and overwhelming events is increasingly recognized as a stable psychological entity. Although they use different labels, Briere (1984), Burgess & Holmstrom (1974), Horowitz (1976, 1980), Figley (1985), Golan (1978), Green et al (1985), Krystal (1978), Lifton (1980), Neiderbach (1986), and van der Kolk (1987) have all described a consistent psychological and physiological pattern, the post-traumatic stress response. This pattern is remarkably

constant across a great range of extremely stressful situations (e.g. combat, criminal victimization, natural disasters). Some elements of the trauma response are likely to occur in most people, regardless of previous level of adjustment (DSM-III, 1980).

According to Scurfield (1985), there has been a prevalent belief that post-trauma psychological symptoms, particularily those which persist over time, are primarily due to pre-morbid personality factors (eg: factors or deficits existing prior to the trauma that "predisposed" persons to manifest psychological or somatic symptoms following the trauma). Such perspectives imply that "healthy" persons must have seemingly unlimited abilities to handle stress.

Many people seem to think that maturity or strength of character or good mental health should prevent a person from falling apart in a traumatic situation. This is simply not the case. Any person who is subject to extraordinary stress will be thrown into a state of emotional termoil and will show signs of stress response symptoms after the removal of the external stress (Horowitz, 1976). Trauma victims in distress are not weak or immature. They are having a natural and appropriate response to a serious threat (Bard & Sangrey, 1980 and Esper, 1986).

The question of how much is predisposition and how much is the effect of immediate stress is hard to clarify because every syndrome will be composed of both sources of influence.

However, some evidence of the "normalacy" of the victim response can be derived by the fact that psychologically, people in traumatic situations have remarkably similar patterns of emotional reactions.

Unpredictable stress that threatens the self is very difficult to manage. Since victims have no advance warning, they are unable to anticipate the effects of stress and gather their resources to withstand them. The strategies the person has used in the past to deal with difficulty may fail him/her completely, and this failure will increase the stress geometrically, short-circuiting the victims self-confidence and further undermining the ability to cope. (Bard & Sangrey, 1980)

The capacity of each person to deal with the trauma depends on a number of variables. The force of a particular traumatic event depends on the victim's previous experience, the symbolic significance of the trauma, and the other circumstances in the victim's life at the moment. Variations in reactions to trauma are due, in part, to individual differences (eg: personality, coping styles, cognitive life assumptions, previous emotional problems), characteristics of the catastrophe and initial reactions to the catastrophe. The victim's developmental history, system of personal meanings, style of relating to the world, relationship to parents, past, personal, social and mental history, age, and sex all enter into the response of the victim. (Janoff-Bulman & Frieze, 1983). Figley (1985) Green, Wilson, & Lindy (1985)

also suggest that certain aspects of the catastrophe experience are important: the role of the survivor in the catastrophe; the degree of life threat, warning, displacement, and exposure to the grostesque.

Six factors apparently affect the long-term adjustment to traumatization: (1) severity of the stressor, (2) genetic predisposition, (3) developmental phase, (4) a person's social support systems, (5) prior traumatization and (6) preexisting personality. Antanovsky (1987); Brull (1967-70); Figley (1985); Frankl (1963); Silver, Boon & Stones, 1983 and van der Kolk (1987) would also add (7) meaning of the event to the person.

Clincial studies reveal the following themes as common problems for the working-through process initiated by traumatic life events:

1) Fear of repetition - persons fear a real repetition and they may also fear repetition in thought.

2) Shame Over Helplessness, Vulnerability or Emptiness - the failure to prevent the event and the emotional state that may follow is regarded as a loss of control.

3) Rage at the Source - anger at any figure felt to be responsible even if that person is only tangentially involved in reality.

4) Guilt or Shame over Aggressive Impulses - destructive fantasies directed toward anyone symbolically connected.

5) Fear of Aggressivity - person fears that s/he will impulsively act out her/his aggressive fantasies in an out-of-control manner.

6) Feelings of responsibility - belief (however irrational) that one has caused or failed to prevent the event from occurring and is therefore responsible (self-blame).

7) Survivor Guilt - (when more than one victim is involved in a traumatic event) the feeling of relief for surviving conflicts with feelings of selfishness and idea that one survived at the expense of others.

8) Fear of Identification or Merger with other Victims- fear of not being separate from the victims that did not survive.

9) Sadness in Relation to Loss - the loss may be another person, an external resource, or an aspect of the self.

10) Negative Self-Image - images of self as weak, frightened, needy or helpless. Self-concept of being out-of control.

While many of the symptoms of stress response are similar, whatever the quality of the external stress, there are also symptoms and signs of stress response that may differ depending on the nature of the stress event. In situations where the victims are subjected to both conditions of isolation and threat of death, the victims are likely to experience hallucinations and sometimes dissociations (Siegal, 1984). Such is often the case in hostage and kidnapping situations. Similarily, incest survivors commonly have dissociative experiences (Briere, 1984, Ellenson, 1986 and Gelinas, 1983) that may not be experienced by victims of other types of trauma (eg: learning of terminal illness). In fact, Ellenson (1986) suggests that the type of disturbances in thought (certain types of nightmares, obsessions, dissociative experiences and phobias) and disturbances in perception (certain types of illusions and visual and auditory hallucinations) may be unique to incest survivors and therefore, predict such a history.

The "Stockholm Syndrome" (Siegal, 1984) or "Traumatic Bonding" (Dutton & Painter, 1983) at first, also seems unique to survivors of hostage and kidnapping. This syndrome refers to an alliance that may form between terrorist and victim whereby both express a fear, distrust, or anger toward authority outside the hostage situation. A similar type of process may be involved in wife abuse, incest, and child abuse. For example, an abused child who is beaten and tortured by a sadistic, cruel parent, still loves that parent, wants to be with that parent and resists attempts at foster placement to a good home or the abused wife may collaborate with the abuser, or try to protect him against anyone who intervens (like police, social workers). However, the Stockholm Syndrome does not appear in victims of natural disaster (Frederick, 1980).

Frederick (1980) differentiates between the effects of natural versus human-induced violence on victims. These differences are outlined in Table 1. As indicated, some of the responses are similar, such as anxiety, insomnia, depression, phobias, etc. What is significant though, according to Frederick, is that victims of natural disasters have no guilt about preventing the event as there is no way one can prevent a flood or a 747 crash. Even more important is that in natural disasters, friends, family, neighbors and emergency teams often get involved both early and later in the course of the event. There is community support, acceptance and empathy for the victim of a natural disaster.

TABLE 1
Effects of Natural vs. Human-Induced Violence upon the Victims *

Major Disasters	Human-Induced Violence/Terrorism
Phases: 1. Initial impact 2 Heroic 3 Honeymoon 4 Disillusionment 5 Reorganization	Phases: 1. Initial impact 2 Acceptance/respect for perpetrators 3 Interaction between victims and perpetrators 4. Disintegration or termination of perpetrators' control 5. Acquiescence/surrender
Psychological Symptoms: Anxiety; insomnia; depression; anorexia; psychophysiological reactions; phobias about the event; little guilt about plight of other victims hostility, resentment, paranoid reactions toward Government officials and persons with fewer losses	Psychological Symptoms: Anxiety; insomnia; depression; anorexia; psychophysiological reactions; phobias about the event; guilt about plight of other victims; mild annoyance and dissatisfaction with actions of Government officials
No guilt about not preventing event	Guilt about not preventing event
No identification with aggressor Desire for reprisal Aberrant characterological acts, *e.g.*, looting deviance alcoholism Wish to return to scene of event "Burn out" among workers and victims	Identification with aggressor Reluctant desire for reprisal No aberrant characterological acts Reluctance to return to scene of event No customary "burn out" among workers and victims
Social Processes: Feeling of loss Acceptance by other persons No humiliation No doubt by others about genuineness of complaints No belief by others that the event was victim-precipitated	Social Processes: Feeling of loss Rejection by other persons mild to marked Humiliation Doubt by others about genuineness of complaints Belief by others that the event was at least partly victim-precipitated
Short-term cohesive feeling among group victims	Long-term cohesive feeling among group victims

*Fredericks, (1980), p. 72.

This is in contrast to a human-induced disaster such as terrorism, personal assault, rape, child abuse, incest, wherein the notion of victim precipitation has been common. That is, the victims' own actions are seen as in part responsible for the violence they experienced. This can accentuate the victims' feelings of guilt about not preventing the event and not making some effort to stop it from running its course. Victims of human-induced violence are often rejected by significant others, perhaps because there is a feeling of guilt by association and fear of contamination when victims are thought to be blameworthy and to have contributed to the event. Victims of natural disasters do not experience the humiliation that victims of human-induced trauma do as there is seldom doubt about the authenticity of their complaints. They are not thought to be blameworthy because the event is an act of God, and no one believes they fantasized the event as the physical evidence of their loss is available for all to see.

It seems evident, then, that the trauma victims' experience can never be reduced to a formula. Violation disrupts the self in as many ways as there are victims. At the same time most victims experience at least some of the feelings and behavior associated with a traumatic reaction (Bard & Sangrey, 1980), and there appears to be some clinical and empirical evidence for a syndrome following trauma (Figley, 1985; Horowitz, 1976; Kyrstal, 1968; Krystal & Neiderland, 1971 and van der Kolk, 1987).

> ...while not negating the powerful influence of pre-stress personality configurations, findings from large groups of persons exposed to the most severe stress indicate that stress-response syndromes are not necessarily limited to any sub-group of exposed population. There is no doubt, then, that general stress response tendencies can be delineated. (Horowitz, 1976,p. 41)

The key issue concerns the existence of a general response syndrome. The word syndrome is defined as a group of signs and symptoms that together are characteristic of a specific condition. Thus, a trauma syndrome consists of a combination of responses that together allow others to recognize that the individual(s) has experienced a traumatic event. The response syndrome can be considered a *general* response syndrome in that all persons would tend to develop such a syndrome after major external stress in adult life, although they would vary in the degree or quality of manifestations of response according to their individual predisposition.

Syndromes and Stages

Krystal (1968,1978) in his clincial observations with survivors of the Holocaust, learned to recognize a syndrome characterized by the persistence of symptoms of "withdrawal from social life, insomnia, nightmares, chronic depressive and anxiety reaction and far reaching somatization." (p. 327) He and others (Jaffe, 1968; Lifton, 1980 and Trautman, 1964, 1971) have observed that the after-effects of persecution have produced a variety of individual and group reactions. Some of the more frequent reactions include

massive denial and repression, brooding depression and self-absorption, "expiatory and propitiatory" tendencies often "masochistically" tinged, psychosomatic symptoms obsessive-compulsive rituals to reduce tension caused by guilt and perhaps also to produce "affective anesthesia" to ward off feelings of fear and guilt.

A frequent clinical picture common to many concentration camp survivors is consists of: (1) a pervasive depressive mood with morose behavior and a tendency to withdrawal, general apathy alternating with occasional short-lived angry outbursts, feelings of helplessness and insecurity, lack of initiative and interest, prevalence of self-deprecatory attitudes and expressions; (2) a severe and persevering guilt complex; (3) somatic symptoms; (4) states of anxiety and agitation resulting in insomnia, nightmares, motor unrest, inner tension, fear of renewed presecution; (5)fully developed psychotic or psychotic-like disturbances; and, (6) personality changes showing a more or less radical disruption of the entire maturational development (Krystal & Niederland, 1971, p. 12-13).

The effects of the concentration camp persecution could be summarized as follows:

1) Survivor guilt - capable of producing depression or anxiety and consequently a wide variety of clinical syndromes.

2) Chronic anxiety - related to the confusion about the present and past, based on the unbearable nature of the past.

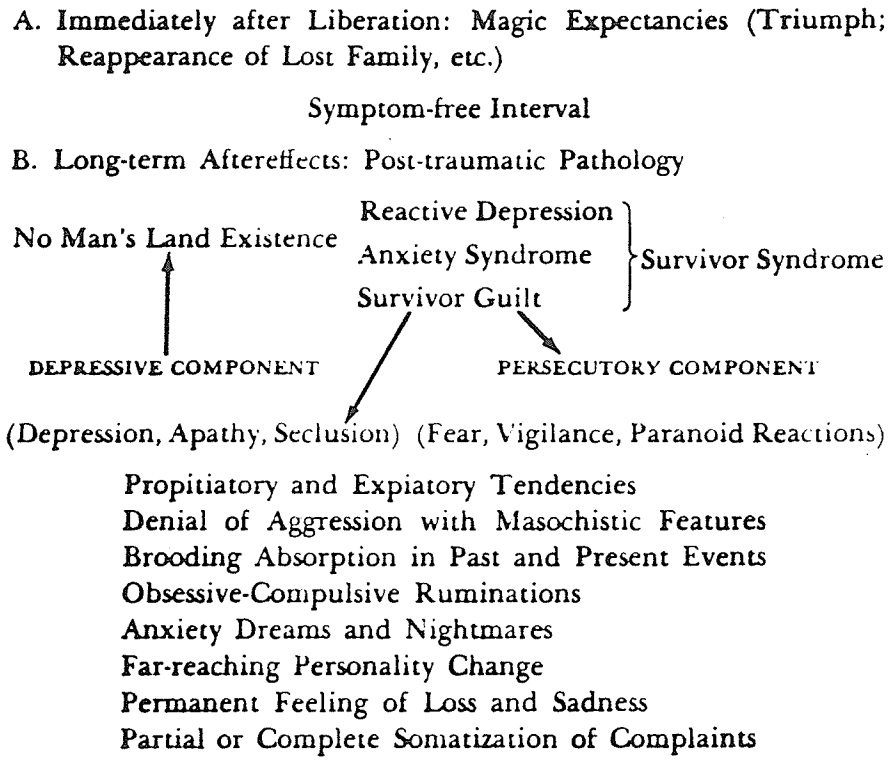
3) Physiological changes - chronic tensions states and various types of vegetative dystonia.

4) Disturbances in intellectual functioning - memory distortions (hyperamnesia or amnesia) distortions of body image and temporal confusion (Krystal, 1968, p. 35).

Krystal (1968) labelled this syndrome the Survival Syndrome and describes it as a mixture of reactive chronic depression and anxiety syndrome, as well as survivor guilt (see Figure 1).

Others also find symptoms that are similiar to those reported by Krystal and have developed their own stage models to describe the emotional reactions of survivors. In studies of victims of violent crime, Bard & Sangrey (1980, 1986) and Symonds (1980) have developed stage models that outline the range of reactions experienced by these victims. Bard & Sangrey identify three psychological stages through which a victim passes after having been victimized. Although the stages often overlap and the victim may relapse to a prior one, they may be identified as (1) the impact stage, (2) the recoil stage and (3) the reorganization stage. The impact or disorganization stage - immediately after the crime the victim falls apart inside. His or her sense of personal intactness and integrity has been shattered. The self responds to violation by becoming disorganized. Victims often feel as if they are in shock. Some victims become numb and disoriented. Physiological disturbances such as the inability to sleep or to eat are common. Disbelief is a frequent reaction. The impact phase is often marked by feelings of vulnerability, helplessness, shame and guilt.

FIGURE 1: Survival Syndrome*



*Krystal (1968), p. 66.

Victims are sometimes filled with a profound sense of loneliness, feelings of isolation, fear and self-doubt. They may become quite childlike and dependent, unable to make even the simplest decisions. Victims seem confused during the impact stage; they may have trouble recalling the details of the crime and may be unable to think clearly or to talk coherently.

In the recoil stage, victims begin to struggle to adapt to the violation and to reintegrate their fragmented selves. The victim needs to deal with a number of distressing emotions including fear, anger, sadness, self-pity and guilt. This phase involves two kinds of activity: sometimes the victim will be able to feel and work on the painful emotions aroused by the experience; at other times s/he will defend against the feelings by denying them. This process has been described as a "waxing and waning of tension" and has been compared to the natural pattern of sleeping and waking. After victims have struggled with the trauma for a while, they become tired and put their troubles aside so that they can rest (Bard & Sangrey, 1986, p. 41).

Both avoiding and facing feelings can be active processes that will use up the victim's energy and absorb her or his attention during this period. Many victims go through a period of direct denial. They feel emotionally detached, unable to respond with much feeling to anything. Between these periods of denial, victims begin to deal with their feelings about the crime. The work of facing these emotions

includes remembering the events of the crime and permitting oneself to re-experience the feelings that have been aroused by the violation. Some victims "play back" the crime repeatedly in their imaginations. They may want to talk about the crime endlessly, reviewing the events in minute detail and dream about it at night.

Fear, anger, rage, and revenge are common and sometimes overwhelming feelings experienced in the recoil phase. Crime victims have a universal need to construct a reason for their violation, to find an answer to the question "Why me?" A great deal of time will be devoted to this task during the recoil phase.

Among the most distressing aspects of the recoil phase, according to Bard & Sangrey (1986), are the great shifts in mood that victims often experience as the second phase progresses. One day they will feel very much on top of things; the next day they are almost overcome again by feelings of helplessness and anxiety. These mood swings are a normal part of the victims' recovery work, but they can be very discouraging and frightening. Victims sometimes feel as if they are going crazy or that they are never going to really recover from their experience.

The recoil phase will eventually give way to the final phase of reorganization. Feelings of fear and rage diminish in intensity and the victim begins to have emotional energy left over to invest in other experiences. The victim's level of activity becomes more even and balanced as the need to

deny the victimization ebbs. Victims think less about the crime and become less interested talking about it, but when it does come up, the conversation is less emotionally tinged and much less upsetting. Although there may be occasional flashbacks of extreme agitation these have become few and far between. The hallmark of this stage is the increased amount of emotional and intellectual energy available for investment in activities unrelated to coping with the victimization. The amount of time necessary for reorganization varies depending on the crime, the more serious the violation, the longer a full reorganization will take.

Symonds (1980) has organized a four phase model of crime victim response as opposed to Bard & Sangrey's three stages. The first two phases form the acute response to sudden, unexpected violence. The first phase - denial is the immediate response to the event and consists of shock, disbelief and denial. In this phase there is a temporary paralysis of action and a denial of sensory impressions. When denial is overwhelmed by reality, victims enter the second phase.

In the second phase victims develop what Symonds calls "Frozen Fright" (hence the name of this stage), which is terror-induced, pseudo-calm, detached behavior. The victim experiences a "traumatic psychological infantilism", in which all recently learned behavior evaporates and only adoptive patterns from early childhood predominate. This behavior appears to include appeasing, compliant, even cooperative and

volunatry acts (going along with the criminal) which confuse everyone including the victim.

This confusion of the victims behavior gives rise to the delayed responses that occur long after victimization. These responses comprise the third stage - <u>self-recrimination,</u> a period of traumatic depression. In this phase, the victim experiences circular bouts of apathy, anger, resignation, resentment, constipated rage, insomnia, startle reactions and replay of the traumatic even through dreams, fantasies and nightmares.

Whereas in the first two phases victims primarily respond to the experience of victimization as a perceived threat to their lives, in the third phase, victims react and review the experience more as if it had been primarily a threat to their pride. They continually replay the scenario of the crime asking themselves "Why did this happen to me?" In this phase of self-recrimination (which Symonds also calls the "I am stupid" phase), the victims review their "wartime behavior under peacetime conditions" and will not accept that all individuals who experience a sudden and unexpected violent act will freeze, submit, or run in panic terror (Symonds, 1980. p.36). In phase three, depressive behavior may appear, fears increase, phobic responses develop and they often form hostile, dependent relationships with family and friends. Others may become more removed from others, develop reclusive behavior and irritability. During this phase they feel angry about being victimized and seek to

blame someone.

In the fourth and final phase - integration, victims may resolve their unfortunate experience and integrate it into their behavior and lifestyle. There is further development of more efficient defensive-alert patterns and profound revision of values and attitudes concerning possessions, and sometimes concerning individuals and groups.

While Krupnick (1980) does not offer a stage model for victims responses, she does report some common signs and symptoms experienced by victims of violent crime. The victims she saw suffered from a variety symptoms, some of which are reported by Symonds (1980) and Bard & Sangrey (1980,1986) although she mentions some additional symptoms. Many reported overwhelming feelings of anxiety, including fears of being alone and fears of going out at night. They experienced intrusive thoughts and images of the event which interfered with concentration. Uncontrollable crying, irritability, insomnia, and nightmares were also common. Another frequent response was depression, sometimes accompanied by suicidal feelings. Some individuals became agitated and restless; others became socially withdrawn. Some attempted to cope with their feelings by increasing their use of drugs or alcohol.

In their study of rape victims, Burgess & Holmstom (1974,1976, 1979) offer a descriptive taxonomy consisting of clusters of common symptoms which characterize the "rape trauma syndrome". They suggest that rape survivors reactions

can be divided into two phases - the acute phase or disorganization and the long-term process or reorganization. The acute phase consists of the difficulties which are encountered immediately after the rape and is characterized by disorganization where the victims may suffer from a wide gamut of feelings as they begin to deal with the aftereffects of the rape. These feelings range from calm to hysteria and include fear, humilation, degradation, guilt, shame and embarrassement to anger, revenge, and self-blame. Victims will frequently express the feelings of being "unclean" and ashamed of what has occurred. They may experience shock, disbelief, and inability to concentrate and make decisions. They feel powerless and are likely to be preoccupied and distracted, unsure and confused. Frequent flashbacks of the attack may cause general sleeplessness and nightmares, or screaming during sleep. Fear of physical violence and death were found to be the primary feelings described by victims in the acute phase. They may fear physical injury, mutilation, or death in reaction to the threat of being killed during the attack. Further, Burgess & Holmstrom (1974) state that because of the wide range of feeling experienced during the acute phases, victims are prone to experience mood swings. The victim can experience a drastic switch from one emotion to the other in very short periods of time (can be compared to being on a roller coaster). They may feel relieved and happy to have survived and suddenly start crying and be overwhelmed with fear or disgust at what has happened to

them. These mood swings can be very frightening for the victims and they may feel like they are going crazy or that they will never be back to "normal".

In the next phase, which Burgess & Holmstrom (1974) call the reorganization phase, victims experience one or more of the following symptoms: continued sleeplessness and loss of appetite, violent and terrifying nightmares and flashbacks, changes in energy level (usually profound fatigue), anxiety, mood swings, crying spells, emotional outbursts, agitation, depression, loss of sense of humor, and repressed anger. The women may develop rape-related fear and panic attacks can occur if they are exposed to a stimulus associated with the rape. They may also develop phobic reactions including fears of indoors (especially found in those women who were attacked while sleeping in bed), fear of outdoors (for those attached outdoors), fear of being alone (reported by almost all the women in Burgess & Holmstroms , 1974 study), fear of crowds, fear of men, fear of being followed or of people behind them, sexual fears (such as fear of resuming sexual relations) and some develop a global fear of everyone.

Initially this phase is characterized by depression, and a prominent manifestation of the depression is that the woman begins to relive the incident. During this time, the woman may resort to constant retelling of the incident, which can lead to additional problems with her family and friends. Although it is not appreciated by those close to her, the persistent retelling is often a very effective method for the

victim to deal with her feelings (Burgess & Holmstrom, 1974).

Lenox & Gannon (1983) state that this phase can be long-term since many facets of the victim's life may be disrupted for a relatively long period of time. A drastic change of the victim's normal routine of living may occur which resembles an attempt to escape the problems by changing jobs or moving to another city, province or country. Many victims are able to resume only a minimal level of functioning. They may go to work or school but are unable to be involved in more than business type activities. Other victims respond to the rape by staying home, by only venturing out of the house accompanied by a friend. A common response, reported by Burgess & Holmstrom (1974), was to turn for support to family members not normally seen on a daily basis. There is often a strong need to get away and have a change of scenery.

In contrast to Burgess & Holmstrom, Sutherland & Scherl (1970) report a three-phase pattern of response to rape. After the acute stage of shock, anxiety, and emotional confusion, victims progress into the second phase in which they seemed to return to normal. This stage is called the recoil phase and contains a "pseudo adjustment" period in which denial and suppression are common defenses. This phase is characterized by attempts to resume normal routine and forget about the rape, thus evidencing an apparent readjustment. According to Sutherland & Scherl, the length of the recoil phase is highly variable and can range from

weeks to years. In the third phase (Integration/Resolution) an inner sense of depression often occurs. This phase is characterized by excessive fear in response to rape related cues, a need to talk about the event, depression, guilt, anger and rumination about the event eventually leading toward readjustment.

Starting with Lindemann (1944) and refined by Horowitz (1976) the response to psychological trauma has been explained through the use of a cognitive model of information processing and is described as a phasic reliving and denial, with alternating intrusive and numbing responses. The intrusive responses are hyperreactivity, explosive aggressive outbursts, startle responses, intrusive recollections in the form of nightmares and flashbacks, and re-enactment of situations reminiscent of the trauma. Van der Kolk (1987) reports that intrusive re-experiencing also may take the form of seemingly voluntary re-enactment: for example some Vietnam veterans enlist as mercenaries, survivors of incest may become prostitutes and physically abused children may expose themselves to constant danger.

The numbing response consists of emotional constriction, social isolation, retreat from family obligations, anhedonia, and a sense of estrangement. It can be understood, according to van der Kolk (1987), as a way of warding off recurrent intrusive recollections of the trauma. Further, he states that traumatized individuals may gain some sense of subjective control by shunning all situations or emotions

related to the trauma. Often they avoid intimate relationships, apparently out of fear of a renewed violation of the attachment bond. Avoiding emotional involvement further diminishes the significance of life after the trauma and thus perpetuates the central role of the trauma.

Horowitz (1976) has found that survivors typically progress through a well-defined sequence of stages when assimilating the trauma. He states that the usual pattern of stress response can be summarized as an initial response of outcry, followed by denial, then intrusion, then working through, and finally completion. Outcry is an almost reflexive emotional expression upon first impact of unexpected new information. The expression may take the form of weeping, panic, moaning, screaming or fainting. In denial there is some combination of emotional numbing, ideational avoidance, and behavioral constriction. A phase in which there will be a gamut of defensive operations aimed at avoidance of the painful aspects of reality. The intrusion phase is a period of unbidden ideas and pangs of feelings which are difficult to dispell, and of direct or symbolic behavioral re-enactments of the stress event complex. Intrusions include nightmares of the stress event, recurrent unbidden images, and startle reactions with perceptual or associational reminders.

Eventually, if "working through" occurs, the new external information is incorporated into the preexisting internal model and, gradually, information storage in active

memory will terminate. At completion, the experience is integrated so it is a part of the individual's view of the world and of him/herself, and it no longer needs to be walled off from the rest of his/her personality.

Individual history and character patterns will effect the order of entry into phases, time in each phase and the clinical manifestations within a phase. As shown in Figure 2, the initial outcry may enter directly into the denial period or even into the intrusive phase. Adult persons may enter the abstract sequence of phases at any point and go through the sequence in any order. However, depending upon the severity of the trauma and the personality of the victim, the survivior may experience a cyclical alternation between avoidance and intrusion stages. In the process survivors report feelings of depression, anger, episodic rage and unconscious re-enactment of the event.

The basic experimental, field and clinical findings about stress response syndromes can be summed up as a list of observations:

1) There are general response tendencies to stressful events, although the degree of response varies with different people, those subjected to enough stress may be expected to show some stress responses.

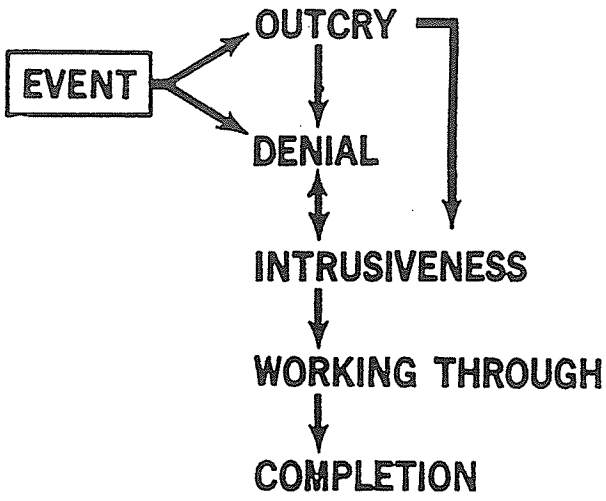
2) The response tendencies are also general in that they may appear after a variety of stress events which differ in quantity and quality.

3) General response tendencies are inclined to occur in temporal phases. Phases may overlap and persons may vary in their entry into and emergence from a phase and in their sequence and termination of phases.

4) Many stress responses persist long after termination and resolution of the external event. Some responses

FIGURE 2

Phases of Response after a Stressful Event*



*Horowitz, 1976, p. 56.

to external stress begin only after an interval of extended relief.

5) In the period after termination of the external stress event, one of the main observations in clinical, field and experimental studies is of intrusive repetiton in thought, emotion, and/or behavior. A set of related but antithetical responses including ideational denial, emotional numbness, and behavioral listlessness are also frequently noted. (Horowitz, 1976, p. 82)

Even though the above mentioned reports of syndromes and stages are reports from differing survivor groups, it can be recognized that there are marked commonalities in the emotional reactions of victims. Common to all of these response models are feelings of disorganization, fear, numbing, anger, intrusive thoughts and images, and denial which occur in some reciprocal, alternating and reverberating fashion.

The recognition of commonalities in reaction across victim types has been furthered by the American Psychiatric Association (1980) Diagnostic and Statistical Manual (DSM-III) and the revised version DSM-III-R (1987). The manual states that Post-Traumatic Stress Disorder describes characteristics that may follow "a psychologically traumatic event that is generally outside the range of usual human experience" and "would evoke significant symptoms of distress in most people" (p.236). In fact, all of the syndromes described earlier might be redefined as Post-Traumatic Stress Disorder.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) was first

acknowledged as a clinical entity in the DSM-III (APA, 1980) and Table 2 is the diagnostic criteria for PTSD which is taken directly from this manual. It should be noted that the disorder includes two subtypes. Acute PTSD occurs when the onset of symptoms is within six months of the catastrophe or traumatic event, but the duration of symptoms is less than six months. Chronic or Delayed PTSD occurs when either or both of the following are found: (1) the duration of symptoms is six months or more (chronic); (2) the onset of symptoms was at least six months after the trauma (delayed).

The central feature of PTSD is that the survivor re-experiences elements of the trauma in dreams, uncontrollable and emotionally distressing intrusive images, and dissociative mental states. Alternately, the victim feels numb (psychic numbing), experiences a loss of normal affect and emotional responsiveness, and exhibits less interest and involvement in work and interpersonal relationships. The re-experiencing of the trauma and the emotional constrictedness are assumed to coexist in the same individual and may occur in cycles, although one phase may predominate in a given individual or time period. Secondary symptoms occuring with the disorder may include excessive autonomic nervious system arousal, startle response, hyperalertness or hypervigilance, memory impairment, depressive symptoms, survivor guilt, avoidance of stimuli with trauma-related associational value, explosiveness, and a loss of capacity for intimacy.

Table 3 indicates that the DSM-III-R (APA, 1987) offers

TABLE 2: Diagnostic Criteria For Post-traumatic Stress Disorder*

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone

B. Reexperiencing of the trauma as evidenced by at least one of the following:
   (1) recurrent and intrusive recollections of the event
   (2) recurrent dreams of the event
   (3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:
   (1) markedly diminished interest in one or more significant activities
   (2) feeling of detachment or estrangement from others
   (3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:
   (1) hyperalertness or exaggerated startle response
   (2) sleep disturbance
   (3) guilt about surviving when others have not, or about behavior required for survival
   (4) memory impairment or trouble concentrating
   (5) avoidance of activities that arouse recollection of the traumatic event
   (6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

*American Psychiatric Association Diagnotic and Statistical Manual of Mental Disorders, 1980, p. 238.

TABLE 3

Diagnostic criteria for 309.89 Post traumatic Stress Disorder

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)
(2) recurrent distressing dreams of the event
(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)
(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

(1) efforts to avoid thoughts or feelings associated with the trauma
(2) efforts to avoid activities or situations that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma (psychogenic amnesia)
(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)
(5) feeling of detachment or estrangement from others
(6) restricted range of affect, e.g., unable to have loving feelings
(7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response
(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.

Specify delayed onset if the onset of symptoms was at least six months after the trauma.

* American Psychiatric Association Diagnostic and Statistic Manual of Mental Disorders, 1987, p. 250-251.

some new diagnostic criteria and goes further than the DSM-III in that it explains some of the experiences that could elicit PTSD. While keeping the delayed subtype, this revised manual does not separate the symptoms into acute and chronic as does the DSM-III. Instead, according to the DSM-III-R, the victim who experiences symptoms in sections B,C, and D for at least one month, is said to be suffering PTSD. Since most victims experience symptoms for longer than one month (Bard & Sangrey, 1986, and Burgess & Holmstrom, 1974) most of the survivors of trauma could be diagnosed as having PTSD and the DSM-III-R incorporates this idea that PTSD can be expected to follow differing types of trauma.

PTSD has been widely examined in veterans of war (Blackburn, O'Connell & Richman, 1984; Breslau & Davis, 1987; Brown, 1986; Card, 1987; Christenson, Walker, Ross & Maltbie, 1981; Foy & Card, 1987; Hayman, Sommers-Fanagan & Parsons, 1987; Horowitz & Soloman, 1985; Langley, 1982 and Silver & Iacono, 1984, and concentration camp survivors and prisoners of war (Boehnlein,et al, 1985; Goldstein,et al, 1987; Kinzie, et al, 1984; Kluznik, et al, 1986; and Krystal, 1968) and before the DSM-III, PTSD was called war neurosis indicating that only war veterans could experience PTSD. More recently, though, PTSD has also been observed and reported in victims of violent crime (Davis & Friedman, 1985; Krupnick & Horowitz, 1980; Ochberg & Fojtik, 1984 and Salasin, 1981)and specifically crimes such as rape (Coons & Milstein, 1984; Holmes & St. Lawrence, 1983; Kilpatric, Veronen & Best, 1985

and Notman & Naleson, 1976), incest (Beck & van der Kolk, 1987, Blake-White & Kline, 1985; Donaldson & Gardiner, 1985; Gelinas, 1983; Herman, et al, 1986; Lindberg & Distad, 1985 and van der Kolk, 1987)and wife assault (Hilberman, 1980; Levitan, 1985 and van der Kolk, 1987). As well, PTSD has been reported in victims of disaster (Lifton & Olson, 1976; Lindy, et al, 1983; McCaughey, 1986 and Titchener & Kapp, 1976) and kidnapping/hostage situations (Terr, 1982, 1983). From this literature, then, there is evidence that PTSD is not limited to war veterans and can be recognized in those who have experienced all types of traumatic situations.

Just to recap, then, symptoms required for a diagnosis of PTSD are:

1) re-experience of the trauma;

2) recurrent intrusive thoughts (recollections);

3) recurrent dreams and nightmares;

4) acting out or feeling as if the traumatic event were recurring;

5) social numbness or withdrawal;

6) hyperalertness or hyperactive startle reaction;

7) sleep disorders;

8) guilt;

9) memory impairment;

10) avoidance of activities that arouse recollection of the event; and,

11) intensification of the symptoms by exposure to similar events.

PTSD is presented descriptively as a set of symptoms

which, taken together, characterize the disorder. This syndrome can also be seen as reflecting a dynamic process by which a survivor attempts to integrate a traumatic event into his or her self-structure. The process itself is a natural one and is not labeled as pathological (ie: a disorder) unless it is prolonged, blocked, or exceeds a tolerable quality (Zilberg, Weiss, & Horowitz, 1982). It might also be argued that in order to be considered pathological this process must interfere with regular functioning to a significant extent.

A crucial element that influences this natural integration of traumatic experiences is the kind of help the victim receives in the moments and days immediately after the event (Saldana, 1987). Saldana states that good, early psychological help can mean the difference between a victim who lives in fear for the rest of her/his life and one who goes on to recognize this feeling, analyze it, work through it and eventually conquer or cope with it. Before concluding this chapter, then, it is necessary to briefly discuss some counselling interventions for trauma survivors.

Counselling Survivors

Therapeutic Intervention

For people who have been abused and traumatized, silence is the greatest barrier to recovery. The breaking of secrecy is the beinning of healing. Therapeutic intervention can

help the healing process and break the cyclical alternation of denial and numbing and intrusive-repetitious thoughts that are associated with trauma, by providing a safe environment in which survivors can freely explore frightening emotional responses. Theoretically, such expression of feelings leads to a "catharsis" or draining of the intensity of the feelings (Silver & Wortman, 1980). However, simple conscious recollection of memories, emotional catharsis, or review of thoughts and beliefs are not enough by themselves (Figley, 1985). They must proceed simultaneously and repeatedly for the best working-through process. It is during this process of repeatedly venting feelings and the retelling of the details of the traumatic event, that survivors begin to understand what has happened and to make sense of their reactions.

Although it is impossible to prescribe in advance the precise course of therapeutic intervention with a trauma survivor, a crisis counselling paradigm seems appropriate for the majority of clients. Most people will gradually begin to integrate the meanings and painful memories of the trauma into their life. Some persons, though, are blocked in this process when current trauma reawakens old wounds that may need to be worked on, or previous conflicts or problems may interact with the current trauma and interfere with the normal processing of the event. For such individuals, symptoms may be particularily intense or prolonged requiring long-term counselling in order to work through the trauma.

Depending on the progress of treatment, the counsellor and client may determine the need for more extensive supportive psychotherapy.

No matter whether short- or long-term counselling is required, the focus of counselling should be on providing information, support and empathy to the survivor. Basically the person who has been traumatized is in need of assurance, understanding and respect and has a right to expect it from the counsellor. The person needs to know that how they are reacting is "normal" given the situation, and that it may take time to "get over", but that the intensity of their feelings will diminish as s/he works the experience through. It is also helpful to prepare the client for some of the feelings that others who have been similarily traumatized have experienced because s/he may also have these reactions (i.e. mood swings, nightmares). In other words, the counsellor should share information and knowledge with the client, about the post-traumatic stress response.

Figley (1985), states that it is essential that the survivors be clearly and quickly educated about salient aspects of the recovery process, and re-educated about these same aspects at later times during the interventions. The most important aspects to bring to the awareness of the survivor are:

a) Trauma is such a catastrophic experience that it can produce post-trauma symptomatology in almost anyone, seemingly regardless of a person's pre-trauma background.

b) It is expected and normal to have intrusive imagery,

numbing, rage, grief, or other symptomatology following a trauma; this may appear during, soon after and/or much later than the trauma.

c) It is not unusual to fear that one will lose control of some emotions (crying, rage, etc.) sometime following a trauma; this does not mean that "you are going crazy" but only that you have some important things to work through about the trauma and its impact on you.

d) The symptomatology "usually gets worse before it gets better" once you start focusing on the trauma and symptoms in therapy; this appears to be a necessary step to work through what you have to work through and it is only temporary. I will be with you throughout this process.

e) PTSD definitely is responsive to treatment.

f) Some symptomatology may not go away completely or forever. Memories or feelings about the trauma may suddenly appear for no apparent reason, or may be triggered by something that seems to be directly or have no particular connection to the past traumatic experience. However, upon closer scrutiny, usually it is possible to find a connection between something in your current life and the appearance of memories or feelings from the past. That will be part of what we will learn more about here, together.

g) Finally, though this may be difficult to believe right now, you may even find that there will be some positive benefits to you and your life through the experiences you have had and your willingness now to face and work through what you must work through. For example, you must be very strong to have experienced what you experienced and be here, talking to me about it today (Figley, 1985, p. 242-243)

The counsellor must also educate the client about the individualized "recovery" process. The client needs to be told that the post-trauma experience is a process of adjusting to the trauma and that everyone experiences this process in their own way and at their own pace. Thus, the client should be encouraged to find her/his own recuperative

rhythm and counsellors must be willing to facilitate "working through" of the trauma at a pace that is comfortable for the client. Moreover, the tendency to rush toward solutions without the full expression of feelings and work on them must be checked.

Counsellors can help facilitate the "working through" process for clients by making contact at a feeling level rather than a factual level, by helping clients identify and focus on their feelings, and by accepting the clients' right to feel the way they feel. Also, counsellors can help clients explore their resources and support systems, help specify goals and issues that clients wish to work on and help to mobilize the clients' strengths and abilities.

The counsellor's understanding and appreciation of the overwhelming nature of the event needs to be communicated to the client. Also, the counsellor needs to let the client know that s/he is believed and that s/he has been victimized. However, since re-experiencing of the trauma is an important part of the "working through" process, the client needs to be encouraged to share the specific and horrifying details of the trauma. It is essential that the survivor be guided through "tolerable doses of awareness", preventing the extremes of denial on the one hand and intrusive-repetitiousness on the other. The client should be encouraged to tell and retell the story to anyone who will be supportive, until the need to tell and the intensity of the trauma diminishes. The survivor may have to repeat the story

of the trauma in many different ways before s/he feels s/he has regained control.

The survivor should be encouraged to work on (rather than block or try to fight) her/his feelings and reactions and be given some positive feedback for the work done so far. A first order of intervention, according to Figley (1985) is to help the survivor decide what will be worked on and in what order and to give reassurance that there will be time set aside to work on the various concerns. Second, it is essential that the survivor be helped to explore her/his coping behaviors, and to sort out which ones have worked and under what conditions. In addition, the survivor can be assisted to refine and add new coping techniques as may be necessary.

Since traumatic experiences often leave victims feeling vulnerable and powerless, one of the goals of counselling intervention is to empower the client and help her/him to regain some control over her/his life. Survivors (especially victims of violent crime) need to be permitted and encouraged to make their own decisions, which provides a first step in overcoming these feelings of powerlessness. In order to facilitate decision making, the client should be encouraged to attend to her/his own body's wisdom, to be aware of emotions and learn to better trust and know what is best for her/himself.

This writer believes that clients have the answers to their problems in living and coping within themselves.

However, the traumatic experience brings clients to counselling in a state of crisis, which involves some disorganization causing the answers to problems to become hidden from clients in their confusion. Supportive counselling allows clients to listen to their inner voice and to trust their own self-knowledge. Thus, it is through the counselling process that clients can rediscover these hidden answers and the ability to make decisions.

The client can further be helped to feel more powerful and in control when the counsellor is able to verbally reframe the client's analysis of her/his experience in ways that allow the client to be more forgiving and compassionate with her/his self. Also, empowerment of the client can be facilitated through gentle confrontation of the client's distortions and self-criticisms regarding how s/he should feel or should have reacted. This gentle confronting of distortions regarding appropriate responses to traumatic events, helps the client to become more accepting of her/his own post-trauma experiences and processes.

A crucial element in the "recovery" process after a trauma is the client's ablity to become self-aware. However, it is also important for counsellors of survivors to be conscious of their own process and emotions when clients share their traumas in counselling sessions. Counsellors need to be aware of the intense pain that can be attached to dealing with traumatic experiences, for their client and for themselves, sharing someone's grief can be difficult and

painful. The sense of panic, fear, and depression can be almost contagious. Often the counsellor will have strong feelings like anger, sadness, frustration. These feelings can be used to help others as they are often clues to how the client is feeling.

Figley (1985) suggests that unusually strong authority and countertransference issues are paramount when working with trauma survivors. The core of the therapeutic effort is the establishment of a trusting and sharing relationship. It is imperative that the therapist continually monitor and confront if necessary her/his own reactions to the client's experience, including the possibility that the client will share information that the therapist will be unable or unwilling to process. Projection of anger by trauma survivors onto persons who may be trying to help them is not unusual. This appears to be particularily true for survivors of human-induced trauma such as rape (Notman & Nadelson, 1976) and the Vietnam war.

Crisis intervention is directed at helping the individual avoid harmful responses and at helping her/him capitalize on her/his strengths and resources as well as an opportunity for growth potential inherent in the situation (each crisis provides the individual with the opportunity to grow even though the growth may involve pain). Well-directed intervention at the appropriate time and place can result not only in a diminuation of serious emotional disturbance, but may also serve as a basis for further emotional development.

Symonds (1980) calls his method of crisis intervention "Psychological First Aid for Victims". The acceptance of the victim's behavior without reservation forms the basis of psychological first aid that all victims need to minimize any psychiatric sequelae from their victimization. Psychological first aid intends to nurture, comfort, and restore the self-respect of the victims for their behavior by giving not taking.

The principles of psychological first aid involve the recognition and sharing of what happened, concern and relief for the safety of the victim, and acceptance without reservation, challenge, or question of the victim's behavior under severe stress. Whether the victim is a four year old molested child or an 80 year old rape victim, the procedure is the same. It can be simply stated in three statements:

1) I'm sorry it happened.

2) I'm glad you are all right/alive.

3) You did nothing wrong.

In other words, the survivor needs the same moral support and words of comfort and caring that you would give to someone who had just lost a loved one.

Immediate Intervention

The Klinic Community Health Crisis Counsellor Training Manual (1988) indicates that immediately following a trauma, victims require immediate attention to their basic needs- are they safe, do they need medical attention, is there a

person(s) who can provide immediate support? The counsellor's job at this point is to provide support, and systems advocacy (arranging transportation, dealing with police). The counsellor must reassure the victim that the trauma is over; that s/he is safe now and what s/he is feeling is "normal" albeit painful and frightening.

When impact reactions develop, such as mood swings, they are often frightening for counsellors to witness and victims to experience, since they appear to reflect a major loss of control. The counsellor may find her/himself labelling the victim as "strange" or "crazy", despite her/his best intentions. It is important that the counsellor recognize emotional lability as a common symptom of traumatic stress response and that s/he reflect the "normality" of mood swings back to the client. By normalizing lability to the survivor (e.g. "Karen, these mood changes usually happen when someone has been through what you have. They will go away pretty soon"), the counsellor may be able to increase the victim's sense of control and lessen her/his sense of panic.

The Klinic manual (1988) also states that the counsellor should see brief dissociative periods as coping mechanisms not pathology. If, however, the client becomes panicked about this symptom, fearing loss of control, it may be appropriate for the counsellor to work with the client to "bring her/him back" to some extent. This can often be done, according to the manual, by having the client speak directly to the counsellor, hopefully making some eye contact. If

physical contact (i.e. touch) is acceptable to the client, it may be helpful. The counsellor should be aware that survivors of assault may find any physical contact with another person either frightening or aversive. However the counsellor chooses to intervene, s/he should do so with as much calmness and gentleness as possible.

One of the most difficult tasks counsellors face in working with survivors is determining how to support and affirm their feelings and statements when s/he is engaged in continual self-blame. There is often the urge to argue with the victim about her guilt. This is rarely an effective strategy, since the client may perceive the counsellor's disagreeing as controlling and punitive. The counsellor must develop ways of affirming and supporting the client's experience of being a victim, while at the same time conveying the fact that the counsellor does not join in her/his self-blame.

Nightmares will generally not be worked with in the very immediate period after a trauma, other than to alert the survivor to the possibility that s/he may experience them, as there are too many other immediate needs that need to be taken care of. The client should be made aware that nightmares are a normal part of the healing process and that they will change and eventually disappear as the working through of the trauma occurs. However, should the client request help with the nightmare, the counsellor can help facilitate this healing process (as will be explained later

in this paper).

Long-Term Intervention

The existence of long-term symptomology should be a cue to the therapist that "unfinished business" exists, and that specific work on emotional issues needs to be done. Three general techniques are of major use in this regard:

1) Reliving the event- The client should be requested to describe and re-describe her/his trauma, with specific focus on her/his feelings at the time. Blocks to feeling should be worked through. For example, s/he may not have grieved over the assault when it happened s/he can be helped to do that now;

2) Catharsis - Encourage emotional discharge. Crying, raging, laughing, moaning, are all curative experiences when naturally released; and,

3) Mobilization of anger - When the client is ready, anger at the assailant, the world (for being an unsafe place) and society (for supporting violence) is a healing experience. Anger also signals that the victim is moving away from self-blame and moving towards blaming the person(s) and conditions which lead to the pain. Externalizing the blame is a natural process, but one which may require considerable support from the counsellor.

Most trauma victims benefit initially from individual therapy. It allows disclosure of the trauma, the safe expression of related feelings and the reestablishment of a trusting relationship with at least one other person. Discussion of the traumatic event(s) and their impact on the client has an organizing effect, allowing the client to see value in the here and now.

However, although no controlled studies exist (van der Kolk, 1987), group therapy is widely regarded as a treatment of choice for those with PTSD, either as a sole form of

therapy or as an adjunct to individual therapy (Burgess & Holmstrom, 1974 and van der Kolk, 1987 and Walker, 1981). Van der Kolk (1985) states that group therapy is the treatment of choice because it is less likely to foster dependence than individual therapy. According to van der Kolk, individual therapy is more likely to promote dependency and the sharing of feelings and experiences with people who have gone through similar experiences promotes the experience of being both victim and helper. Thus, the group allows for more flexible roles with mutual support and alternating positions of passivity and activity and clients can start re-experiencing themselves as being useful to other people. Most importantly, group work is extremely helpful in combating feelings of isolation and shame (Bass & Davis, 1988 and Burgess & Holmstrom, 1974).

Since the impact on the survivors social support systems is usually significant, this writer prefers a combination of individual and group therapy for trauma survivors. A combination of therapies is ideal because it allows "the best of both worlds" (the benefits of group and individual therapies) and provides contact with more supportive persons for clients. Survivors seem to have to tell and retell their trauma experience and family and friends often become tired or have difficulty repeatedly listening to their loved ones pain. Individual therapy allows clients to experience consistent and undivided attention from one other individual (who is there specifically to listen to survivors talk about

their experience). Group therapy allows clients to recognize that others are having similar reactions to the trauma and normalizes their post-trauma experience. As is often the case, though, time, energy and availability of both types of counselling, may not make this a viable option for all trauma victims.

In short, appropriate interventions include acknowledgement, respect, and validation of the person inside the pain, seeing her/him as real, valuable, competent and sane. Even the concept of the person as "victim" may make a helper/counsellor less able to view the person as active, mastery-seeking and capable (Lee & Rosenthal, 1983). The major lesson learned in conceptualizing and counselling survivors is to respect the strengths of people who have experienced such events. The fact that individuals survive and grow in the face of such onslaughts attests to the resiliency and tremendous strengths of human beings. It should always be kept in mind that people can be powerless in preventing their own victimization, while powerful in coping with it (Janoff-Bulman, 1985).

The ideal intervention, then, does not minimize or pathologize the trauma and/or the survivor's reactions to the trauma. The long-term psychosocial and therapeutic challenge is to guide the survivor through the anger and fear of "why me?" into mastery and reintegration (Bard & Sangrey, 1986).

Summary and Conclusion

This chapter has explored the human reaction to trauma. The material presented has shown that the traumatic response can take many forms depending on a number of interacting variables. One can expect that regardless of the trauma experienced, the survivor will respond in a manner that incorporates any of a number of reactions. Each victim responds in a unique way. Because symptoms vary from person to person and from situation to situation there are a variety of different "syndromes" as opposed to a universal syndrome. In other words, just as there is no universal initial reaction to trauma, there is no single "trauma syndrome". However, there are clusters of symptoms that are common to trauma survivors' experiences. These common symptoms or syndromes are labelled by the American Psychiatric Association as Post-traumatic Stress Disorder.

Esper (1986) has argued, as this writer has, for a relationship between traumatic experiences and PTSD. However, Esper (and this author) strenuously object to the use of the term "disordered" when describing behavioral and emotional changes following a severe trauma such as criminal victimization. It is helpful to reconceptualize such reactions as adjustment strategies which allow rather than inhibit "healthy" psychological functioning. A less pathologizing label might be Post-traumatic Stress Reaction.

This chapter has also explored a number of stage models designed to represent the human reactions to trauma. Silver

& Wortman (1980) state that there is a pervasive belief among caregivers and helping professionals in the existence of sequential stage models of emotional reactions. Stage models enable the care-giver to better prepare both distressed persons and their loved ones for the type and length of expected reactions and enable health-care professionals to identify those individuals who manifest unusual reactions. Also, a stage model provide some kind of yardstick by which to assess progress.

On the negative side, use of a stage model of recovery can lead to the professional losing sight of the individual's unique experiences with responses like "Oh, you're in the second stage now, that behavior is to be expected" or "Oh, he's just going through the anger stage" instead of looking at legitimate reasons for the individual's anger. Some "helpers" might even force the individual to experience trauma in the "proper" way (i.e. go through the stages). Those that do not follow the stages, then, might be labelled as deviant or pathological.

While empirical evidence is lacking regarding the existence of stage models (Silver & Wortman, 1980), the stages are helpful in alerting us to the patterns that <u>may</u> occur and provide an outline within which to place the individual's unique experience. It should also be noted, that all authors of stage models of reaction admit to the flexibility of these stages and to the possiblity of individual differences.

What seems to make sense and provides a better description of the reaction process is to look at reactions in terms of acute and long-term responses. Also, cycles or alternating phases give a more accurate picture of the post-trauma experience.

This paper has reported that there are similarities in the experiences of survivors of a wide variety of catastrophes, both in terms of their emotional reactions and in terms of their attempts to rebuild shattered assumptions. In stressing similarities, however, it is not meant to suggest that differences do not exist. Knowing how survivors react in general does not enable us to predict how an individual will react to a particular type of victimization or to predict the course of the healing process.

The integration or healing process involves re-experiencing the trauma through intrusive thoughts and images. Part of this natural integrating process is the experiencing of post-traumatic nightmares. In fact, nightmares can be an expected reaction for those who experience a life-threatening trauma. In the next chapter, post-traumatic nightmares will be explored in more detail.

CHAPTER 2

POST-TRAUMATIC NIGHTMARES

This chapter will present an overview of the literature on post-traumatic nightmares. Comparisons will be made between ordinary nightmares, night terrors and post-traumatic nightmares. As well, there will be a brief discussion of the current sleep and dream research as it relates to nightmares. Life-long nightmare sufferers will be compared to traumatic nightmare sufferers and the role of post-traumatic nightmares in the post-trauma healing process will also be discussed.

Before defining and comparing the different types of nightmares it will be helpful to describe the sleep process for the adult population. Evidence of the normal sleep pattern is compiled from the works of Dement, 1974, Fiss, 1979 Hartmann, 1984, Kales & Kales, 1974.

As a person falls asleep, her/his brain waves, as measured with an electroencephalographic machine (EEG), go through certain characteristic changes, classified as stages 1, 2, 3 and 4. The waking EEG is characterized by alpha waves (brain waves of eight to twelve cycles per second- c.p.s.) and low-voltage activity of mixed frequency. As the person falls asleep, s/he enter stage 1, the lightest stage of sleep, and begins to show a reduction of alpha activity.

The period just prior to sleep onset is called Stage W

(Fiss, 1979) and refers to a drowsy waking stage, EEG is characterized by alpha waves which are regular in form, have frequency of 8-12 c.p.s. and a fairly low-amplitude or voltage. Muscle activity and REMs (rapid-eye-movement) are both present. As the person falls asleep, s/he enters Stage 1 which is also called sleep onset stage. EEG is more irregular, has a somewhat lower frequency (4-8 c.p.s.), but amplitude remains low, muscle activity is present and so are eye movements but they are slow and rolling (SEM).

In Stage 2 the EEG pattern shows frequent spindle shaped tracings which are brief bursts of fast (12-16 c.p.s.) low voltage waves (sleep spindles). Also present are high voltage spikes known as "K-complexes", which are sharply rising and falling high amplitude waves. The spindles and K's are interspersed amidst an irregular, low frequency (3-4 c.p.s.), low amplitude pattern. Muscle activity is present, but eye movements are absent.

Stage 3 contains a moderate amount (20-50%) of very low frequency (1-2 c.p.s.), high voltage waves (activity at 0.5 to 2.5 c.p.s.) called "delta" waves. Spindles and K-complexes continue to appear occasionally. Muscle activity is present, but there are no eye movements.

In Stage 4, delta waves occupy the major part of the EEG record and this stage is characterized by bursts of REMs and muscle activity suppression. Stages 3 and 4 are also called slow wave sleep (SWS).

Sleep is divided into two major categories, rapid-eye-

movement (REM) sleep and nonrapid-eye-movement (NREM). REM sleep has also been called "active sleep" because breathing becomes irregular- very fast, then slow - and under the eyelids the eyes dart around back and forth. Other distinguishing factors include irregularity in pulse rate, respiratory rate, blood pressure, absence of muscle tone interrupted by sporadic movements in small muscle groups. Persons awakened during this period report that they have been dreaming, while persons awakened from stages 2, 3, or 4 sleep very seldom report dreams (Hartmann, 1984).

NREM sleep is composed of sleep stages 1, 2, 3 and 4 and is often called "quiet sleep" because of the slow, regular breathing, the general absence of body movement, and the slow, regular brain activity shown on the EEG.

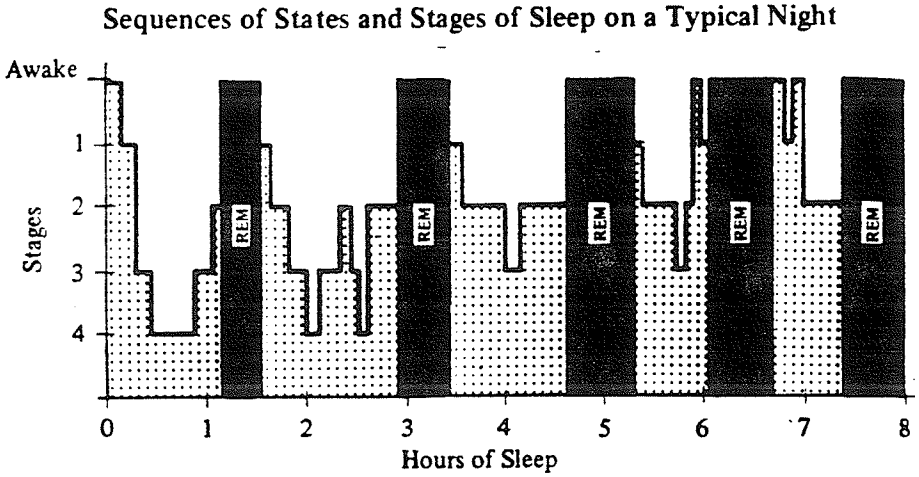
As shown and further explained in Figure 3, the sleep stages are occur in cycles, with four or five periods of emergence from stages 2, 3, and 4 to a stage similar to stage 1. Each cycle is similar to the others except that as sleep progresses, REM periods lengthen, and the descent of sleep may only reach stages 3 or 2. The number of cycles of REM periods varies between four and six nightly, depending on the length of sleep. REM sleep constitutes about 20 to 25 per cent of the total sleep time.

In a typical night's sleep then, an individual would descend from NREM stage 1 to NREM stages 2, 3, and 4 and then ascend back up until emerging into REM. A complete cycle lasts on average 90 minutes. This means that the first REM

FIGURE 3: Sleep Stages*

This figure is a plot of REM sleep, NREM sleep, and the four stages of NREM sleep over the course of one entire night of sleep. Although it is a "real" night from one particular subject, it is also a representative night. In other words, with a few minor changes, most nights of most people would show the identical sequence of events. The time spent in NREM sleep is lightly shaded and the time spent in REM sleep is shown in black. NREM sleep always is the first to occur at the beginning of the night. It is abnormal to go from daytime wakefulness directly into REM sleep. The first period of NREM sleep usually lasts about an hour and then gives way to the first period of REM sleep. From the onset of sleep to the end of the first REM period is the first *sleep cycle*. From the end of the first REM period to the end of the second REM period is the second sleep cycle, and so on. Thus, the cyclic alternation of NREM and REM sleep is what constitutes the basic sleep cycle that is often referred to in the literature. The average periodicity of this cycle is ninety minutes, although individual cycles may show considerable variation in length. The first sleep cycle is usually somewhat short, about seventy to eighty minutes; the second and third are usually longer than average, 100 to 110 minutes; later cycles tend to be a little shorter.

As you can see, Stages 3 and 4 dominate the NREM periods in the first part of the night, but are completely absent during the later cycles. Thus, we say that sleep is deepest in the first third of the night because we feel that it is harder to wake people up from Stage 4 sleep. The amount of Stage 2 sleep becomes progressively greater as the night wears on until it completely occupies the NREM periods toward the end of the night. The first REM period is usually relatively short, five to ten minutes, but tends to lengthen in successive cycles. Here again, individual REM periods show great variability in length, although the overall average is about twenty-two minutes. Toward the end of the night, very brief periods of wakefulness may interrupt sleep. This happens to each of us nearly every night although we may never even notice the little awakenings. In this example of an entire night, the brief periods of wakefulness were in NREM sleep, but short awakenings often occur in REM sleep as well.



*Dement (1974), p. 114.

phase of the night can be expected to occur roughly an hour and a half following sleep onset, after 70-100 minutes of NREM sleep. Once completed the cycle repeats itself approximately 5 times per night, with NREM always preceding REM sleep. In the early part of the night sleep is dominated by the NREM state, particularly Stages 3 and 4, but as the night wears on, REM sleep periods become progressively longer, and Stage 2 represents the only NREM interruption. An adult who sleeps seven and one-half hours each night generally spends one and one-half to two hours in REM sleep. Since people who are awakened during REM periods usually report dreaming, it can be said that we dream roughly every ninety minutes all night long.

Now that the general characteristics of sleep have been presented, the chief differences between nightmares, night terrors and post-traumatic nightmares can be examined.

Nightmares

For centuries, nightmares were thought to be evil spirits who inhabited the soul when the person was asleep (Morris, 1985). Nightmare episodes were thought to be caused by a nocturnal demon pressing upon the chest of the sleeper, because a sense of respiratory oppression was commonly reported by persons awakened by them. This demon or spirit was known as a *mare* in Old and Middle English, and a similar concept was evident in the Old High German and the Old Norse word *mara* meaning incubus. The English word "nightmare" is

derivied from the German word *Nachtmar* which means "nocturnal devil". Similarily the term "incubus attack" derives from the Latin *in* and *cubare* , which means "to lie upon" also referring to this sense of respiratory oppression (Keith, 1975).

The etymology of the word nightmare, studied by Jones (1951), is quite complex. However, the theme of an oppressing powerful force or creature that threatens to overwhelm or destroy the sleeper seems to be common to all the possible origins and definitions (Mack, 1970).

> The Anglo-Saxon *mare* was a demon, deriving from the Sanskirt *mara* , or destroyer, which, in turn, may come from mar, to crush. Similarly, the French word for nightmare, *cauchemar* , is compounded from root together with *caucher* , to tread upon. Later, possibly in the latter part of the Middle Ages, the root *mara* became assimilated with the English word *mare* or female horse... This meaning of the word is linked with the highly sexual significance of some nightmares, the horse being a ready symbol for a powerful, active sort of sexuality. The attribution of the nightmare to an incubus, a mythical male demon that seeks to lie with women, or to a female succubus that lies similarly with men, also suggests a sexual significance. The Latin *incubare* , to lie on, from the English incubate, also has a sexual significance. (Mack, 1970, p. 3)

According to Mack (1970), if the sexual significance of a nightmare is demonstrated, there is still the need to explain why such sexuality should be overwhelming, terrifying, and associated with violence, crushing and destruction. He suggests that it is probably "no more correct to attribute all the violence of nightmares to sexual impulses than it is to explain all violence in waking life on

the basis of sexuality (Mack, 1970, p. 3).

The term nightmare is frequently and has traditionally been used when referring to night terrors in adults and has also been used to identify the anxiety dream which occurs during the REM portion of the sleep cycle (the common "bad" dream of adults and children).

Hadfield (1954) suggests that the distinction between an anxiety dream and a nightmare is one of degree rather than of kind. He uses the term nightmare specifically for those anxiety dreams of such intensity that they completely overwhelm the personality; they give rise to exaggerated bodily sensations as palpitation, sweating and suffocation, which are indeed the natural accompaniments of intense fear. Jones (1951) also suggests that nightmares are determined by the intensity of anxiety experienced by the dreamer. He maintains that there are three cardinal features of nightmares: (1) agonizing anxiety and dread (2) a sense of oppression or weight at the chest which alarmingly interferes with respiration and (3) the feeling of helpless paralysis.

Nightmares, then, are nocturnal episodes of intense anxiety and fear associated with a vivid and emotionally charged dream experience (Kales, Soldatos, Caldwell, et al, 1980). Mack (1970) defines the nightmare as an anxiety dream in which fear is of such intense degree as to be experienced as overwhelming by the dreamer and to force at least partial awakening. Similarly, Morris (1985) states that nightmares are severe anxiety dreams where the fear and the issues in

the dream are so intense that they wake up the dreamer. They occur during regular REM sleep, usually last fifteen to twenty minutes and are often complex compilations of scenes that can be remembered in great detail. Many people have recurring themes and actions in their nightmares; common themes are: paralysis, suffocation, falling, drowning, death, being nude in public, wandering on a lonely road, being chased or followed, trying to get someplace and not being able to find the road, not being able to lock doors against intruders, not being able to open doors when being chased, having to take an exam in a subject you have never studied, being an actor on stage and not knowing your lines (p. 212-214).

Anxiety dreams are similar to nightmares in their themes and feelings of fear but are not as intense and do not cause the dreamer to awaken in fright. These dreams can be very disturbing, whether or not they are remembered, because the feelings of anxiety and fear can linger even when the person does not recall what evoked them (Morris, 1985).

Hartmann (1984) reports that the typical nightmare occurs later during the night, or the second half of the sleep period. The nightmare occurs during REM sleep and is definitely a dream - a long, frightening dream which awakens the dreamer with unmistakable detailed recall of vivid and intense dream experience, accompanied by anxiety and some autonomic arousal (Fisher, Bryne & Eward, 1970).

Factors that make nightmares more frequent or intense,

according to Hartmann (1984) are:

1) Physical illness - there is some question as to whether it is the actual illness itself or the stress that accompanies it.
2) Mental Illness - onset of psychosis, schizophrenia, depression.
3) Stress - of various kinds.
4) Traumatic events.
5) Certain medications - 1-DOPA, reserpine,thioridazine, mesoridazine, tricyclic antidepressants, benziazepine and other drugs used for treatment of high blood pressure and beta-adrenergic blockers. Abrupt with-drawal from REM-suppressant drugs (tricyclics) generally induces REM rebound, which may be associated with increased intensity of dreaming and with the occurrence of nightmares (DSM-III-R).

Hartmann also states that nightmares appear to be especially frequent in situations that involve helplessness or remind people of childhood feelings of helplessness and that in most persons a sense of safety or protection reduces nightmares.

The DSM-III-R (1987) categorizes frequent nightmare sufferers as having Dream Anxiety Disorder sometimes called Nightmare Disorder (p.308-309). The manual states that the essential feature is repeated awakenings from sleep with detailed recall of frightening dreams. These dreams are

vivid and quite extended and usually include threats to survival, security, or self-esteem. Often there is a recurrence of the same or similar themes and the dream experience or the resulting sleep disturbance causes significant distress.

According to the DSM-III-R, dream anxiety episodes occur during periods of REM sleep. Therefore, they are more likely to be experienced toward the end of the night, when REM sleep is more abundant. Further, the manual states that upon awakening from the frightening dream, the person rapidly becomes oriented and alert. Usually a detailed account of the dream can be given both immediately upon awakening and in the morning.(DSM-III-R)

Hersen (1972) concluded that the occurrence of nightmares appears to be a rather common phenomenon, both for normal and pathological populations. Hartmann (1986) suggests that nearly everyone will have an occasional nightmare, particularily under stress, but that persons with frequent (over once per week) nightmares are less common. He has noted that nightmares are more common in children than in adults. In several other studies, though, it has been demonstrated that frequent nightmares are a relatively prevalent experience in the adult population (Belicki & Belicki, 1986; Halliday, 1987; Hersen, 1972 and van der Kolk, Bliz, Burr, Sherry & Hartmann, 1984). Other examples such as, Haynes & Mooney (1975) report that 25% of 284 students surveyed had nightmares at least once a month and Belicki

(1985) report that 20% of 210 undergraduates experienced 12 or more nightmares within the previous year. Also, Cernovsky (1984) report that 50% of 60 Swiss university students had a nightmare within the previous 2 years of his survey. Further, the DSM-III-R (1987) lends support to the pervalence of nightmares by stating that about 5% of the general population report a current complaint and another 6% a past complaint of nightmares.

Briefly, then, nightmares are intense anxiety dreams. The events of the dream are usually vividly recalled and involve a sense of danger and helplessness and the occurrence or threat of violent attack directed at the dreamer. These nightmares occur during REM sleep and are experienced by people of all ages.

Night Terrors

Night terrors and nightmares are distinctly different phenomena, although the terms have often been used interchangeably by those unfamiliar with the distinctions. Night terrors are intense and striking phenomena that are experienced by 1-4% of children during sleep but only rarely found in adults (Kales, Cadieux, Soldatos & Kales, 1982). The first 10 minutes of the night terror (also referred to as a *pavor nocturnus* in children and *incubus attack* in adults) frequently involve: (1) intense feelings of anxiety, (2) an increase in heart rate by as much as 100 beats per minute within a 15-30 second period, (3) an increase in the rate and

amplitude of respiration, (4) profuse perspiration, (5) fixed and staring eyes, (6) an intense scream and/or cry, (7) heightened motility, and (8) an inability to be awakened (Broughton, 1968; Fisher, Bryne, Edwards, & Kahn, 1970).

The first notable discovery about night terrors was that they originated from Stage 4 sleep (Broughton, 1968) and not from REM sleep wherein dreams were known to arise. The laboratory studies of Fisher & associates (1970, 1974a,b) have also found that the severity of the night terror was directly related to the amount of time the individual spent in Stage 4 sleep before night terror onset.

Although the attack is initiated out of stage 4 sleep, it takes place in an EEG stage approaching that of light sleep or wakefulness. The EEG shows a sudden shift from delta (slow wave) activity to an alpha rhythm (awake pattern). The subject appears to be dissociated, out of contact with the environment, delusional and/or hallucinating. Although the subject is not asleep when the night terror is enacted, s/he is not in a fully alert waking state either (Keith, 1975).

According to Keith (1975) night terrors consist of a sudden change from quiet sleep, usually in the first third of the night, during which the sleeper shows violent bodily activity and marked evidence of physiological activity. There is tachycardia with the pulse nearly doubling from the resting state, rapid, irregular deep breathing, dilated pupils and often sweating. The face is contorted by fear,

and there is usually crying or screaming. The sleeper acts confused, verbalizations are generally present, but disorganized. S/he may walk around, bump into things, and perform nonpurposeful or bizarre acts. The episode is difficult to interrupt by holding, comforting or attempting to arouse the sleeper. It subsides in one to twenty minutes, at which time quiet sleep quickly recurs. For some, the episode may be repeated several times in the course of one night, and in the morning, there is amnesia for the entire event. Usually only a single frightening feeling or sensation is remembered.

The full blown night terror is a fight-flight episode combining sleep-talking, sleepwalking, and hallucinated and delusional mental content associated with terror (Fisher, et al 1970' Fisher, Kahn, Edwards, Davis, 1974a and Fisher, Kahn, Edwards, Davis & Fine, 1974b). It is characterized by the following features:

1) it is ushered in by loud piercing screams of bloodcurdling and animal-like intensity, associated with verbalizations, cries for help, cursing, moaning, groans and/or sighs;
2) sudden, violent breakthrough of uncontrolled anxiety out of Stage 4 sleep in the early part of the night;
3) during the latter modified waking state the subject is dissociated, relatively unresponsive to the environment, shows decreased cortical responsiveness and may be delusional and/or hallucinating;

4) the hallucinatory-delusional state is often accompanied by motility and somnambulism (sleepwalking), the subject being propelled out of bed and moving through the house as though in flight or engaging in defensive fight reactions. Subjects occasionally hurt themselves or commit violence;
5) there is intense autonomic discharge, increase in heart rate (doubling or tripling within 15 to 30 seconds), and tremendous increase in respiratory amplitude; and,
6) there are varying degrees of amnesia for content of the night terror and the behavioral manifestations associated with it (Fisher, et al, 1974a, p. 388-390).

Night terrors can be distinguished from nightmares, then, in that they occur in slow wave sleep (Stages 3 and 4) rather than during REM sleep. In most cases, nightmares can be easily differentiated from night terrors on the basis of their general clinical characteristics (see Table 4 for a summary of the major differences). The night terror is accompanied by more anxiety, vocalization, motility and autonomic discharge. Also, following nightmares, individuals generally have a clear and vivid memory of their dreams. The content recalled from nightmares tends to be much richer, more elaborated, and sequential (Fiss, 1979). In contrast, very little content is generally recalled from night terror episodes; the most recall one usually gets is a single

TABLE 4: Differentiation of Night Terrors and Nightmares*

	Nightmares	Night Terrors
EEG characteristics	Stage 1, REM period	Stages 3–4, NREM period
Occurrence	Throughout night; predominate in later periods of REM sleep	Early in sleep (90–120 min); first REM period typically
Anxiety	Minimum—easily dispelled	Maximum—difficult to control
Arousal	Gradual increase in pulse rate; moderate autonomic arousal; responsive to environment	Rapid increase in pulse rate intense autonomic arousal unresponsive to environment
Memory for content	Clear and vivid	Confused, vague; generally amnesia for event
Incidence	Common	Rare—less than 1–4% of the population

* Carlson, White & Turkat (1982), p. 459.

fleeting, frightening image or thought (Fiss, 1979).

Unlike nightmares, night terrors are not dreams. They are shorter duration (1 or 2 minutes whereas nightmares average 20 minutes duration), and occur earlier in the night (often within an hour of falling asleep). In the night terror, the frightening content does not build up gradually as in the REM nightmare, but occurs instantaneiously (as is indicated by the rapid acceleration of heart rate and respiration).

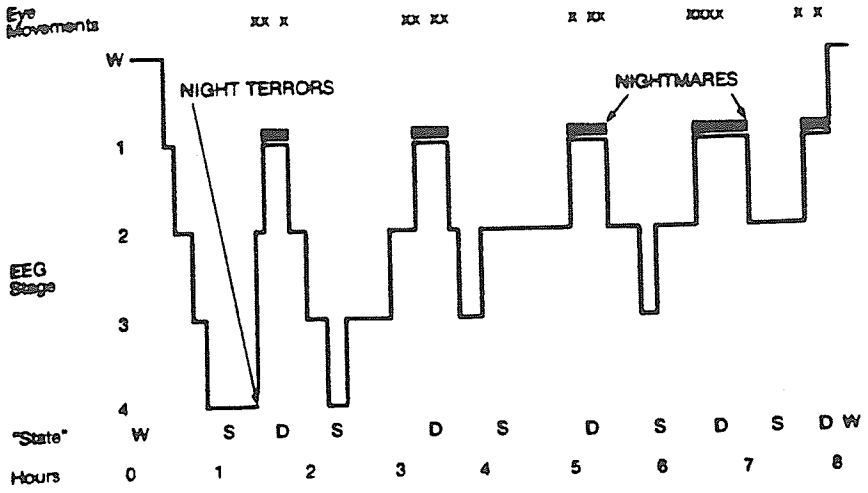
Figure 4 shows that night terrors and nightmares differ significantly in EEG characteristics, in that night terrors occur duing Stage 3-4 slow wave, NREM sleep, whereas nightmares occur during REM periods of sleep. In addition, nightmares occur throughout the night but predominantely during the later periods of REM sleep, whereas night terrors occur early in sleep (Kales, Kales, Soldatos, et al, 1980).

The night terror is relatively rare in occurrence whereas the REM nightmare is very common and is present as a normal phenomenon from infancy to extreme old age. The literature indicates that the incidence of the night terror is about 3% in children and even less in adults, is greatest between the ages of 5 and 7, and is far more common in boys. The symptoms may be present from early childhood and continue practically unabated for 20-25 years (Fisher, et al, 1974a).

From the evidence presented above, it is clear that night terrors have distinct clinical manifestations and that they can be distinguished from nightmares. However, the

FIGURE 4

Sleep Stages and Occurance of Night Terrors and Nightmares*



Night Terrors and Nightmares in the Sleep Laboratory
NOTE: Night terrors occur early (often within an hour of falling asleep), during stage 3 or 4 sleep. Nightmares occur toward morning, during REM or dreaming sleep (see text).

*Hartmann (1984), p. 19.

confusion between these two extremely different entities makes past literature on nightmares difficult to interpret; for instance, well-known works on "nightmares" by Jones (1951), Kramer (1979) and Mack (1970) include detailed descriptions making it clear that both phenomena are included. It is important to make distinctions between the different types of sleep disturbances in order that the correct diagnosis can be made and the appropriate treatment undertaken. As mentioned earlier in this paper, another type of nightmare that disturbs sleep, the post-traumatic nightmare, will be the focus of this paper and will now be discussed.

Post-Traumatic Nightmares

After any traumatic experience the individual re-experiences or relives the trauma in the form of nightmares and flashbacks (see chapter 1). Traumatic nightmares are often very realistic, repetitive and faithful to the actual memory of the traumatic event (Hartman, 1984; Hersen, 1972; Kales & Kales, 1974; Mack, 1970; and van der Kolk, Blitz, Burr, Sherry & Hartman, 1984). The realism of the traumatic nightmare is what distinguishes it from the ordinary nightmare which may include fantastic elements and may be difficult to understand.

According to van der Kolk (1987), immediately after the trauma traumatic nightmares usually occur frequently. After a while they subside, but they often recur, sometimes after

decades of latency, in response to psychologically or biologically important events such as puberty, marriage, the birth of a child, the onset of physical illness, or retirement (van der Kolk, 1987).

Traumatic nightmares are often characterized by imagery, speech, thought, and emotion, and resemble dreams in many ways so that one would assume that they are nightmares and not night terrors, yet they have unusual features. The content is repetitive, more like a memory than like a dream or fantasy, a memory that is replayed over and over. And sometimes these traumatic nightmares occur within an hour or two of sleep onset, not at the typical time for nightmares (the later hours of the night).

Some workers consider post-traumatic nightmares to be night terrors. According to Hartmann (1984), at times, the experience definately resembles the night terror (e.g. awakening in terror early in the night, with a scream, autonomic arousal, and occasionally a sleepwalking episode). Some persons who experience night terrors report that the episodes began with a trauma or at least a period of stress. For example, Kales and associates (1980) reported that over one-third of their group of night terror sufferers had "major life events" that preceded and may have initiated the night terror episodes. Kramer, Schoen, & Kinney (1984) have shown that they can induce a traumatic nightmare in a veteran suffering from post-traumatic stress disorder by a partial arousal early in the night, suggesting the traumatic

nightmare may be a phenomenon of arousal (similar to Broughton's, 1968 statement that night terrors are disorders of arousal). Fisher, et al (1974a,b) also found that they could induce an episode of night terrors by sounding a buzzer. In this sense, the traumatic nightmare resembles the night terror more than it does the nightmare.

On the other hand, a traumatic nightmare resembles an ordinary nightmare in many ways. Traumatic nightmares are usually experienced as a dream. Similar to the nightmare sufferer, the traumatic dreamer has vivid recall of dream content containing imagery and thought and there is intense fear associated with the dream. Also, traumatic nightmares, like ordinary nightmares, are common - they occur to some extent after any trauma. As well, the traumatic nightmare and ordinary nightmares are experienced by all ages - children, adolescents and adults. Thus, the post-traumatic nightmare is similar to an ordinary nightmare too.

Van der Kolk, et al (1984) found that traumatic nightmares in people with Post-Traumatic Stress Disorder, tend to occcur early in the sleep cycle and are accompanied by considerable body movements (characteristic of night terrors/Stage 4 sleep) but they often have elaborate content (characteristic of REM anxiety dreams). Thus, they concluded that traumatic nightmares have characteristics intermediate between the two most commonly described nightmare phenomena, REM anxiety dreams and night terrors.

Other researchers (Greenberg, Pearlman, & Gample, 1972;

Hartmann, 1984; and Lavie, Hefez, Halperin & Enoch, 1979), have also found post-traumatic nightmares in Stage 2 and 3 sleep as well as REM sleep. Sometimes the same nightmare, in terms of content has been reported from awakenings out of different stages of sleep (Lavie, et al, 1979). For example, Hartmann (1984) studied one veteran with post-traumatic nightmares in the laboratory and found the same nightmare content occurred in REM and in Stage 2 sleep.

The sleep stage does not seem to determine the degree of emotional distress experienced during the nightmare, but it probably does account for the amount of visual imagery present (van der Kolk, 1987). Further, van der Kolk (1987) states that although evidence is far from conclusive, it appears that REM nightmares are dreamlike and often have mixtures of other experiences, whereas Stage 2 and 3 nightmares are usually exact movie-like recreation of the traumatic experience itself.

The literature indicates, then, that the traumatic nightmare's relationship to the stages of sleep is not certain at this point. It appears likely, though, that typical traumatic nightmares can occur in several stages of sleep, perhaps any stage of sleep. This ability to occur in any stage of sleep makes post-traumatic nightmares distinctly different from either the ordinary nightmares or night terrors.

Post-traumatic nightmares are recurring and have been known to occur for long periods of time, sometimes decades,

after the traumatic event has ended (Archibald, Long, Miller & Tuddenham, 1962; Breger, Hunter & Lane, 1971; Burstein, 1986; Courtois & Watts,; 1982; Donaldson & Gardner, 1985; Garfield, 1987; Horowitz & Soloman, 1985; Kramer, Schoen, & Kinney, 1987; Susulowska, 1985; Terr, 1983; Wilbur, 1984; and Wilmer, 1986). For this reason some researchers began to inquire into the differences (in personality and nightmare experiences) between those who experienced recurrent traumatic nightmares for long periods of time and those who suffered from lifelong nightmares (frequently recurring nightmares-nontraumatic).

Van der Kolk, et al (1984) examined how the nightmares and personalities of veterans with persistent traumatic nightmares following combat differed from those of veterans with no combat experience who suffer with lifelong nightmares. They found that chronic traumatic nightmares of men who had been in combat differed from the lifelong nightmares of veterans with no combat experience. The traumatic nightmares tended to occur earlier in the sleep cycle, were more likely to be replicas of actual events and were more commonly accompanied by gross body movements. The lifelong nightmares were described as long, frightening dreams occuring in the second half of the night (similar to ordinary nightmares). The nightmares of the lifelong nightmare group seemed consistent with their daytime concerns.

Even though the veterans had not seen any actual combat,

the content of their nightmares frequently involved frightening war-time scenes, sometimes based on combat experiences of friends or combat scenes they had read about, the content was variable and was not a replay of a single traumatic event. These men also had non-combat nightmares of being chased, being unable to escape, being in catastrophies, and other themes similar to civilians with lifelong histories of nightmares. Sometimes the combat and non-combat themes merged in a single nightmare.

Hartmann, Russ, Oldfield, Sivan & Cooper, (1987) and Kales, et al (1980) have described a consistant personality pattern in their subjects with life-long nightmares. They were characterized as passive-dependent people with feelings of insecurity and inferiority, as worriers who had difficulty forming stable and mature interpersonal relationships. Kales and associates described such subjects as having a schizoid pattern of adjustment, while Hartman and associates thought them to be unusually open and creative.

This research indicates that individuals who suffer from post-traumatic nightmares can be distinguished from those who suffer from recurring nightmares by personality, nightmare experiences and nightmare content. It is also clear that post-traumatic nightmares are a distinct phenomena and can be distinguished from ordinary nightmares and from night terrors. Before discussing methods of working with traumatic nightmares, it will be helpful to first examine the re-experiencing phenomena and the function of post-traumatic

nightmares in the post-traumatic stress response.

Re-experiencing The Trauma

Many writers have tried to explain the re-experiencing phenomena that occurs for survivors after traumatic events (whether the re-living occurs in the form of waking flashbacks, the compulsion to retell traumatic events, or in sleeping nightmares). A summary of some possible explanations follows.

Greenberg & van der Kolk (1987) state that the traumatized individual is compelled to recall the trauma involuntarily. This tendency to involuntarily re-experience, in either the verbal or visual realm is generally understood as an attempt to come to terms with, or to integrate, the strong affects and somatic sensations invoked by the trauma into the fabric of one's life experiences. It is an attempt to assimilate an initially unassimilable experience, to convert an unimaginable event that has happened into a memory (Rycroft, 1979).

Dreistadt (1972) suggests that the person tends to repeat and relive her/his traumatic experience because s/he wishes to desensitize the experience and to abreact its painful emotion. The individual repeatedly relives the trauma in order to be able to obtain rational control over her/his exaggerated impulse to act heroicly so that s/he can master dangerous situations more successfully in the future. The purpose of the development of the traumatic neurosis, and the anxiety dreams that go with them, is to warn and

frighten the person so that s/he will not again behave in a way that will place her/him in unnecessary danger (Dreistadt, 1972).

A cognitive model of information processing is used by Horowitz (1974, 1976, 1985) in an attempt to explain the re-experiencing involved in post-traumatic stress disorder. His approach assumes a completion tendency in which the psychological elements of the event remain in active memory storage until a traumatic life event can be successfully integrated into the existing self-structure. Horowitz, et al. (1980) hypothesize that the active memory has an intrinsic property of repeated representation. The process of integration, or a synthesis between new information and what the individual already knows, is set in motion by each representation. When inner cognitive models accord with the news, it is reinterpreted, and a point of completion is reached. The active repetitive property is terminated as the event becomes part of both long-term memory and expectancy schemata.

Freud (1965) tried to include nightmares in his general view that dreams are fulfillments of wishes by suggesting that nightmares were wishes for punishment. The observations of combat reactions, however, especially the symptoms of recurrent nightmares which repeated scenes of terror, forced him to revise his theory of dreams. He recognized that the recurrent nightmares of combat were not wish fulfillments, that they were "beyond the pleasure principle" and were

manifestations of "compulsion". (Horowitz, 1976). He went on to suggest that certain nightmares, especially traumatic nightmares represent a repetition compulsion (a form of defense involving a primitive tendency of the mind simply to repeat what has been experienced). He posited a need to master the traumatic event as a motive for compulsive repetitions. Thus, the traumatic dream can be conceptualized as an attempt on the part of the ego to "master" a traumatic event by repetition. By actively recreating the event rather than passively experiencing it as in the original situation, the individual can gradually master the experience.

Levitan (1980) also suggests a role of wishfulfillment for traumatic dreams. Unlike Freud's earlier wishfulfillment theory, though, he transfers the locus of the wish from the dream itself to the post-dream waking state and suggests that the survivor's ego wishes to undo the trauma. The survivor, therefore, incorporates the traumatic event into the dream so that s/he can wake up and state: "It was unreal, it did not really happen, it was just a dream!"

Similarily, Renik (1981) suggests that post-traumatic dreams represent wishfulfillment. However, rather than a wish to be punished, he saw post-traumatic nightmares as disguised fulfillments of the dreamer's wish to be reassured. Thus, according to Renik, a traumatic event is faithfully and repeatedly replicated in a traumatic dream because the actual event can be reassuring as well as disturbing. While a traumatic event stirs up dread unconscious fantasy, producing

a sense of danger, it also gives evidence that the danger has been in reality escaped. Therefore, the dreamer goes over and over the real circumstances of the event in order to confirm that "That was bad, but not as bad as it might have been".

Renik (1981) goes on to state that the kind of repetition that takes place in a traumatic dream (and in waking flashbacks) is an effort at mastery, consisting of the self-administration of repeated doses of reassurance. Exact repetition permits the dreamer to confirm that reality proves to be different from the fantasy and safe. Moreover, this effort at mastery expresses a wish, namely that a narrow escape from danger signifies safety for the future. The dreamer reassures her/himself in a way similar to that of the soldier who wears "the bullet that missed" on a chain around his neck (Renik, 1981, p. 178). Thus, in its function of providing reassurance, the traumatic dream is at one and the same time an effort at mastery and a wish fulfillment. Reassurance of success in the future is sought through recollection of a success in the past.

Basically, the theories on the re-experiencing phenomena presented so far are all suggesting that re-experiencing serves the function of adaptation to the trauma. When examining the specific function of traumatic nightmares, since traumatic nightmares are experiences like dreams, it is necessary to look at the theories put forth regarding the adaptive function of dreams. These theories concerning the

adaptive function fall into two broad categories: compensatory and mastery (Dallett, 1973).

Mastery

The mastery hypothesis (Bonime & Bonime, 1962; Cohen & Cox, 1975; Stern, 1978; and Ullman & Zimmerman, 1979) suggests that dreams help the individual to master or handle stressful experiences. In the mastery formulation of adaptation to stress, dreams help the individual to work through the stressful experience by presenting or rehearsing elements of that event. Further, some theorists suggest dreams help the individual to master or handle a stressful expeience by allowing the dreamer to integrate the event with similar past, stressful experiences (Breger, Hunter, & Lane, 1971 and Cohen & Cox, 1975).

Wright & Koulack (1987) hypothesize that dreaming is an opportunity for the individual to deal with situations that s/he was prevented from handling as a result of the demands of waking life. Their model assumes that attempts at mastery begin at the time of occurence of the stressful stimulus and are dependent on a number of factors - individual personality, personal relevance of the stressor, nature and duration of the stressor. According to Wright & Koulack, dreaming and traumatic nightmares allow the dreamer to continue to work on the stress presented in her/his waking life.

In contrast, Greenberg, Pearlman & Gampel (1972)

considered traumatic nightmares to be a reflection of the dreamer's continuing attempt to deal with the trauma and her/his continuing failure to master it. They suggest that dreaming serves the adaptive, coping, mastering functions of the ego and that traumatic nightmares are an example of unsuccessful functioning of dream ego. These authors hold a view similar to Freud's (1965) view that nightmares are unsuccessful attempts by the ego to master the overwhelming aspects of the traumatic event. Fisher, et al (1970) would agree, and conclude that post-traumatic nightmares do not serve to master anxiety, but rather represent a massive failure of the ego to control it.

Hall (1966) does not suggest that traumatic nightmares represent a failure. Rather, he states that the repetition in dreams of actual traumatic situations helps the ego overcome severe experiences of helplessness and passivity by re-living them until some form of mastery can be achieved by the dream ego. This notion is part of a broader explanation frequently offered for traumatic nightmares which holds that the repetition of a traumatic experience "turns passive into active". In fact, Levitan (1965) states that the need to turn passive into active is a major motivation operating in a post-traumatic dream. However, Renik (1981) argues that in traumatic dreams the dreamer's experience is every bit as passive and terrifying as it was in actuality and one is hard put to find evidence of an increased sense of control on the dreamer's part in a traumatic dream.

This author suggests that the re-experiencing phenomenia, in traumatic nightmares and in waking life flashbacks, is part of a continuous process of integration and healing. Reliving the trauma is also an attempt to incorporate information into long-term memory for future reference (possibly to help the individual cope in similar situations should they occur again). However, the traumatic experience is so powerful and overwhelming that it takes the mind several attempts (replays) to complete the integration process. Thus, replaying the trauma is not a failure of the mind to control anxiety, but is a normal process of integration and consolidation of experience into long-term memory. The mind naturally goes over experiences and plays back interactions and experiences in order to make sense of the information and to process it into memory.

Rachman (1979) calls this process of integration into memory Emotional Processing and states that it is a process whereby emotional disturbances are absorbed and decline to the extent that other experiences and behavior can proceed without disruption. Successful processing can be gauged from the person's ability to talk about, see, listen to, or be reminded of the emotional events without experiencing distress or disruptions. It makes sense then to say that when an individual experiences distress at being reminded of the event, it may not be a failure on the part of the mind but instead may indicate that the processing is not yet finished.

The following example may help to explain this process. If you think of an interaction you have had today, a conversation, discussion or argument, you will notice that after the interaction you may have gone over the interaction maybe once, twice or more. You may have said things to yourself like "I should have said this when she said that" or "If what he said is true then...." and you may have continued the conversation in your head for awhile. But, at some point you stopped thinking and going over the interaction and your mind went on to something else. This writer believes that the experience described in this example, which occurs at some time for all of us, is on a continuum with what happens after a trauma. The traumatized individual goes over and over the event in her/his waking and dreaming life in order to process and store the information about the experience.

Information processing is also mentioned by Dewan (1970) as a function of dreams. He proposed that during dreams the information from the day is sorted and stored much in the same way as a computer stores information. His "P" hypothesis suggest that following a stressful experience, incorporations of stressful elements in the dreams would be an integral part of the information-processing mechanism. Therefore, traumatic nightmares can be seen as part of a process that integrates new and significant experiences into the schemata of a dreamer's experiences, so that either old or new memory organizations are available for dealing with

these challenging situations.

Support for the mastery theory is indicated by some of the studies that examined the effects of stressful pre-sleep experiences on dream content (Breger, Hunter, & Lane, 1971; Cohen & Cox, 1975 and Greenberg, Pearlman & Gampel, 1972). Using a demanding intellectual task as the stressor, Cohen & Cox (1975) found that subjects who incorporated elements from the experimental situation in their dreams expressed a marked positive change in "state of mind" (p. 91) or affect from presleep to postsleep mood. They interpreted this as evidence that dreams serve a mastery function in adaptation to stress.

Unlike Cohen & Cox (1975), Breger, Hunter, & Lane (1971) collected dreams following "real life" experiences. In one study they examined the content of dreams of subjects who were participating in group therapy sessions. They found that the material aroused during the stressful group sessions was incorporated and worked through in their dreams. These authors proposed that the changes in dream content obtained following stressful experiences are indications that the dreamer is attempting to master the stress by integrating some of its elements, along with their anxious connotations, into the dream.

In another study, Breger, et al (1971) also investigated the dream content of patients both before and after major surgery. They found that themes of cutting and other surgical procedures dominated the patients' dreams. Material

from the stressful surgical experience appeared to be integrated with or assimilated into an organized network of older memories which also were present in the dream content. The authors suggested that psychologically aversive stimuli are transformed into forms familiar to the dreamer which allow her/him to integrate the new stimuli by means of mental processes that have been adaptive in the past.

These studies indicate a mastery function for dreams in adaptation to stress. However, at least one theorist (Wright, 1988) suggests that in order for a dream to fulfill a mastery function, some change or consequence in the content of the dream should follow the dream. Further she suggests that incorporation of stressful elements in dreams is not necessily equivalent to mastery but rather may be evidence of the operation of a mastery function. Yet, since dream experience and waking experience are intimately related (Faraday, 1972, 1976; Freud, 1965; Garfield, 1974, 1987; Hall, 1966; Hall & Nordby, 1972; Jacobi, 1973, Jung, 1964, 1974; Kramer, 1988; Mallon, 1987; Quinn, 1981; Shohet, 1985; Toombs & Toombs, 1985 and Ullman & Zimmerman, 1979) change in the content of the dream may not be the only way in which the mastery function need be assessed. For example, the nightmare may inspire the dreamer to make changes in her/his waking life (thoughts, flashbacks or behavior). Therefore, these changes may be evidence that the dream plays a mastery function in stress adaptation.

In summary, the mastery hypothesis suggests that

repetitive nightmares, as well as other phenomena that the individual seems compelled to repeat in a seemingly irrational fashion, represent an effort to transform a traumatic experience, in which the individual was passive and painfully helpless into one of active mastery (Mack, 1970). Dreams help the individual to work through the stressful experience by presenting and rehearsing elements of the traumatic event and may act as a reassurance for the dreamer having survived a traumatic situation.

Compensatory

Although both theories suggest that dreams provide an adaptive function, the compensatory theory is in direct contrast to the theory of mastery. The mastery theory states that the dreamer rehearses the stressful situation in her/his dream. The compensatory theory, on the other hand, suggests that the dreamer dreams of a situation that is opposite to the stressful experience. Rather than the dream helping the individual to work through or master the stressful experience by presenting elements of the event and allowing the dreamer to integrate stress with the memory of solutions to past stressful experiences, the dream psychologcially compensates for the event with dream content that is inconsistent with elements of the stressful experience.

Jung (1974) proposes a theory of compensation in his approach to dreams. He states that the general function of dreams is to restore the psychological balance. Further, he

suggests that dreams restore balance by presenting elements that are either complementary to or missing from waking experience. In this way, dreams augment the waking experience and supposedly help the individual adapt to the situation.

The compensatory theory is also put forth by DeKoninck & Koulack (1975). They suggest that following a stressful experience, dreams might be less anxious, even pleasant, and would contain fewer incorporations of stressful elements. Compensation is suggested by dream content that is discontinuous or inconsistent with elements fo the waking stressful situation.

Support for the compensatory theory comes from studies which examine the effects of stressful presleep experiences on dream content (Hauri, 1970; Kramer, Whitman, Baldridge, & Ornstein, 1966; Foulkes, Pivik, Steadman, Spear & Symonds, 1967 and Susulowska, 1985). Hauri (1970) studied subjects who participated in physical acitivity or a problem solving activity just before sleep. He reported that subjects who engaged in physical activity prior to sleep experienced dreams with little or no reference to exercise. Those subjects who had worked on problem solving tended to have dreams which were unrelated to this activity.

Similarily, Kramer, et al, (1964) found support for the possibility that dreams play a compensatory role in response to certain types of physiological events. After injecting subjects with a muscle relaxant and a tranquilizer, they

found an increase in motility in subjects dreams. The authors go on to suggest that the dreams may have been providing compensation to the individual for being deprived of movement.

In another study, Foulkes, et al (1967) collected the dreams of young males following the presentation of a film about either baseball or a violent western. They found that the dreams of the boys who viewed the baseball film contained more aggression and hostility than the dreams following the western film. The authors suggest that their study gives evidence to support the compensatory theory.

Evidence for the compensation theory is also reported by Susulowska (1985). She studied the dreams of concentration camp survivors and found that while imprisoned, the content of the prisoners dreams was related to the individuals urgent needs - such as hunger (e.g.:dreams about mounds of food). Wish-fulfillment dreams were most frequently dreams of being home, being with family as well as dreams of pleasant things from back home/youth. For the most part, Susulowska found that the dreams the prisoners had in the camp offered an escape from reality. It seems that the dreams transported the prisoners to another and happier world, permitting them to be with their family and friends, to admire the beauty of nature and to delight in it, to return to their youth. Dreams were a kind of interlude, a bright moment in the grim reality. Sleep brought respite from the camp and dreams performed an additional function by enabling them to be with

the persons they loved and longed for. Susulowska concludes that compensation through dreams was undoubtedly one of the important factors that helped the prisoners survive.

If one is to interprete Susulowska's findings within a compensatory model, the dreams of the concentration camp survivors would suggest a striving for psychological balance. This striving for balance is indicated by the fact that the dreamers dreamt of conditions that were opposite to their real life situation. While imprisioned they dreamt of pleasant experiences instead of the real horrible conditions they lived in. Thus, they were able to compensate for the reality of their life situations in their dreams which, according to the compensatory theory, allows for psychological balance or homeostasis.

The studies mentioned above indicate that dreams may serve a compensatory function in adaptation to stress. The authors suggest that dreams with content that is inconsistent with elements of the waking stressful situation may compensate for and help the individual adapt to the stressful event. However, other theorists discussed below, speculate that dreams may serve both a mastery and a compensatory function in adaptation to traumatic events.

Mastery-Compensatory

Kramer, Whitman, Baldridge & Lansky (1964); Wright (1988) and Wright & Koulack (1987) hypothesize that dreams might change or serve more than one function in stress

adaptation. Dreams may include a rehearsal or repetition of the event and then a progression from that event in order to establish balance and eventually adaptation to the trauma. Instead of a mastery or a compensatory function, then, dreams could serve both functions at different times in the post-trauma process.

One proponent of this theory (Wright, 1988) states that the mastery-compensatory theory is a dynamic process of adaptation to stress that involves two phases. Initially, the individual attempts to work through, rehearse or master the stressor. The individual's dreams might reflect these attempts by containing actual elements of the stressor along with anxiety. As the adaptation process continues and some degree of mastery is attained, the need to compensate for the stressor becomes dominant. Dreams at this point would be complementary to the stressful event and pleasant in nature. Further, Wright suggests that this process reinstates psychological equilibrium and the individual is better able to adjust to the stressful situation. Wright believes that the adaptation to stress is an on-going dynamic process starting at the time of the occurrence of the stressful situation and continuing through the individuals's waking and sleeping life until s/he achieves some resolution of the trauma.

Wright's (1988) theory is consistent with the disruption-avoidance-adaptation model proposed by Wright & Koulack (1987). The disruption-avoidance-adaptation model

involves an oscillation between disruption and avoidance. Disruption refers to alteration of dream content resulting from stressful stimuli occurring either during wakefulness or sleep. Disruption occurs because the process of mastery insofar as it calls up the stressful stimulus and associated affect into the dream is itself potentially disruptive.

Avoidance refers to attempts to achieve homeostasis after the dreamer has been subjected to disruption. Avoidance is used to replace the concept of compensation. Compensation hypothesis suggests that dreams serve an adaptive function by providing a dimension of experience that complements that of waking life.

Avoidance takes three general forms: (1) dreams may contain elements of a thought or activity that had previously been missing from waking or sleeping experience; (2) they can be complementary in affect to stressful waking or sleeping experience; or (3) they can simply be dreams that have no apparent relationship to the stressful experience. Also avoidance dreams may take place in the same night as disruptive dreams or on subsequent nights.

According to the disruption-avoidance-adaptation model, incorporation into the dream of elements of the stressful waking experience may represent attempts to obtain mastery of the event. However, the process of dreaming about the traumatic event may itself be stressful and so the individual may then experience dreams that are unrelated or complementary to the stressor as a way of avoiding an

obtaining temporary relief from the stressor. The authors suggest, then, that mastery (disruptive) dreams are replaced by pleasant (avoidance or compensation) dreams in order to achieve homeostasis. Further, they suggest that if the individual has not successfully dealt with the stressor the dreams will again address the stressful event in an attempt to master the stress. This oscillation between functions of the dream is expected by the authors to continue until the individual is able to obtain resolution of the traumatic event.

Wright & Koulack's (1987) theory of the oscillation between mastery and compensation in the adaptive function of dreams is consistant with Horowitz's (1976) Stress Response Syndrome mentioned in Chapter one. He recognized two main aspects of the individual's response to trauma, the intrusive repetitive tendency and the denial-numbing tendency, as alternating phases of intrusive-repetitions and denial that individuals experience in response to a traumatic event. Further, Horowitz suggested that the trauma survivor experienced these two phases in an alternating pattern until there was a resolution or completion of the trauma experience.

The intrusive repetitive tendency, according to Horowitz & Becker (1971), is an automatic property of mental information processing which serves the function of assimilation and accomodation - a kind of "completion tendency". The denial numbing tendency is thought to be a

defensive function that interrupts repetition-to-completion in order to ward off intolerable ideas and emotions.

It follows that the dream process of adaptation after a trauma would be similar to the adaptation process found to be experienced in waking life. This seems especially likely since, as mentioned earlier, dreaming is related and reflective of the waking experience. Also, there is an assumption of continuity between our waking and sleeping lives (Kramer, 1988).

Wright & Koulack (1987) would suggest that if an individual is able to deal with a stressor in waking life, avoidance dreams are expected to occur. If the stressor is not successfully dealt with in the waking state or if it is pushed aside because of the desire to avoid the issue or because of pressing concerns of the day, it is expected that the stressor will appear in the dreams of the night as the dreamer attempts to find a measure of mastery. Therefore, the two processes of healing and adaptation are not seen as mutually exclusive by this writer or by Wright & Koulack. However, this writer would add to Wright & Koulack's suggestion, that the individual may be able to work with or deal with the stressor/trauma in the dream which would aid in the adaptation to the stressful situation in waking life.

Previous research has not been designed to examine a possible interrelationship between the mastery and compensatory function of dreams (Wright, 1988). However, there are a few studies which give evidence to indicate that

the master-compensatory theory is a possiblity. For example, De Koninck & Koulack (1975) presented a film showing industrial accidents to subjects before sleep and again in the morning. They found that subjects who exhibited more emotionality at the morning film presentation were those who had more elements of the film incorporated in their dreams. Thus, it appears that film incorporation interfered with the adaptation to stress. The authors indicate that these findings appeared more consistent with the compensation hypothesis than with the mastery hypothesis since those who were less affected by the film at the morning presentation tended to be those who did not dream about it. However, the occurrence of anxiety at the second film presentation, for subjects who had incorporated film elements into their dreams, might have been an indication that the adaptation process was not yet complete for those subjects (Wright, 1988). Further, Wright (1988) hypothesizes, if more time had intervened between the two film presentations for the subjects in De Koninck & Koulack's (1975) study, then it is possible that adaptation to stress would have been accomplished and their dreams would have been pleasant in nature with little reference to the stressful film presentation. Therefore, De Koninck & Koulack (1975) conclude that certain aspects of their study indicate that adaptation to stress in dreams occurs by means of a compensation or avoidance mechanism while other aspects indicate a mastery process.

Additional evidence of both a mastery process and a compensatory process operating in dreams can be found in Wright's (1988) study of the adaptation of dreams to stress following a stressful intellectual activity. Subjects were exposed to either an easy or a difficult "aptitude test". Then, each subject recorded dreams and completed mood assessments at home on six consecutive nights. Pre- and post-test mood measures revealed that both versions of the aptitude test induced stress in subjects. She found that for both test groups (easy and difficult) there was a trend toward more treatment incorporation in dreams across nights. The easy test subjects reported an initial increase and then a decrease in negative affect across nights while the difficult test subjects expressed alternating levels of negative affect across post-stressor nights. Wright concluded, then, that dreams serve both a mastery and a compensatory function and speculated that dreams oscillate between the two dream functions until the dreamer attains adaptation to the stressor.

The study by Susulowska (1985), may also indicate evidence of the mastery-compensatory function of dreams. In her study, she noted that the content of the dreams experienced during imprisonment was different from the content of dreams experienced after release. The dreams that the former prisoners now have are anxiety dreams that are very unpleasant. The prisoners dream most often about tense situations such as attempts to escape from the camp and the

dreams are always accompanied by a paralyzing fear. They also dream about their concentration camp experience and their life during the occupation - shooting, escapes, lost documents, round ups, and the desire to save the family accompanied by the inability to act. Although the dreams do not always directly refer to situations at the camp, they clearly relate to it.

It seems possible that while the survivors were in prison, overwhelmed with harsh conditions and needing all their energies directed at survival that the compensation function of dreams may have been dominant. When they were safely released and able to meet their basic needs, the mastery function of dreams may have become dominant allowing them to rehearse the trauma in attempts to master it. Thus, the on going stress may have been too overwhelming while in the camp and the person was unable to deal with it until released and safe from the traumatic situation. Now that the survivors do not have to spend all their energy trying to survive they are able to deal with the trauma in their waking thoughts and dreams. In other words, the dreams the prisoners had while they were in the concentration camp seem to support the compensatory theory while the dreams they have today seem to support the mastery theory. However, when taken together the evidence from Susulowska's study seems to support the mastery-compensatory theory.

It should be noted, though, that the Susulowska study did not collect information about the content of dreams that

the immates experienced at the beginning of their internment. These dreamers may have had traumatic nightmares related to being captured, the train ride to camps, the separation from family, or other experiences they had undergone upon arrive at camp. Thus, the dreams may have been serving a mastery function at first, changed to a compensatory function, then back to a mastery function.

It is not possible to tell from this research or from the other research cited here, whether dreams do in fact perform a mastery-compensatory function. In order to determine if the master-compensatory theory is correct, long term research that follows the process of dream content and waking life experiences from the beginning of the traumatic event is necessary. However, it would be difficult to know how long this long term study should be and since there is a continuation between waking and dreaming experiences, the coping mechanisms that the trauma survivor ordinary uses in waking life would have to be examined along with the coping mechanisms found in her/his dreaming experience.

Summary and Conclusion

This chapter has focused on nightmares. A comparision was made between ordinary nightmares, night terrors and traumatic nightmares and it was noted that post-traumatic nightmares are distinct phenomena that can be distinguished from both night terrors and ordinary nightmares in a number

of the following ways.

Ordinary nightmares are intense anxiety dreams. The events of the dream are usually vividly recalled and involve a sense of danger, helplessness and the occurrence or threat of violent attack directed at the dreamer. Typically nightmares occur during regular REM sleep in the second half of the sleep period, they last 15 to 20 minutes and are common occurances and are experienced by people of all ages.

Unlike nightmares, night terrors are not dreams and very little content is generally recalled from a night terror episode. They occur in slow wave sleep during the first third of the night in Stages 3 and 4. Night terrors involve more intense anxiety, vocalization, motility and autonomic discharge than ordinary nightmares. They generally last one to two minutes and occur early in the night (often within an hour of falling asleep). As well, in the night terror the frightening content does not build up gradually as in the REM nightmare, but occurs instantaniously (as is indicated by a rapid aceleration in heart rate - as much as 100 beats per minute within a 15-30 second period - and increase in respiration). Also, night terrors are relatively rare in occurance and are usually found in children rather than adults.

Post-traumatic nightmares, on the other hand, are different from both ordinary nightmares and night terrors. They are accurate repetitions of the preceding traumatic experience and resemble dreams in that they are characterized

by imagery, speech, thought and emotion. Yet, the content is repetitive, more like a memory than a dream or fantasy, a memory that is played over and over. Typically traumatic nightmares can occur in several stages of sleep and in fact can occur in any stage of sleep. They have been found to occur early in the night (within 1 or 2 hours of sleep onset), in Stage 2 and in Stage 4 as well as in REM sleep. They are commonly experienced by children and adults, after any life-threatening trauma.

The re-experiencing phenomena that occurs for survivors after a traumatic event was also examined in this chapter. Some explain re-experiencing or re-living the trauma as an attempt to come to terms with the trauma (Greenberg & van der Kolk, 1987), a method of integration or new information storage (Rycroft, 1979), a wish to desensitize the experience (Dreistadt, 1972), a wish to be reassured of survival (Renik, 1981), cognitive information processing involving a completion tendency (Horowitz, 1976) or a repetition compulsion (Freud, 1965).

In this chapter, it was also noted that the re-experiencing function of traumatic nightmares is thought to serve as an adaptation to the trauma. The theories of the adaptation to stress function of nightmares fall into two categories, the mastery theory and the compensatory theory. The mastery theory suggests that the dream allows the dreamer to master the trauma by rehearsing the stressful event. The compensatory theory indicates that the dream aids in

adaptation to stress by incorporating content that is opposite to the actual stressful event thus creating psychological homeostasis for the dreamer.

As well, a new theory of the adaptation function of dreams was discussed. This theory by Wright (1988) and Wright & Koulack (1987), states that dreams may oscillate between mastery and compensatory functions in order to allow adaptation to the trauma. It was noted that the master-compensatory theory is most consistent with evidence presented on the post-trauma reaction (see chapter 1) and it seems logical that the dreaming reaction to trauma would be similar to the waking reaction to trauma because dreams are a continuation of the waking experience (Kramer, 1988).

In order to further determine the function of nightmares in the post-trauma healing process it was determined that long-term research is needed. This research should examine the immediate reaction to trauma in dreaming and waking life as well as the progression or process that healing takes as it occurs. Much more information is needed before a firm conclusion can be reached on the adaptive value of post-traumatic sleep and dreaming. However, at this time it appears that there is a continuation between waking and dreaming life and that dreaming provides an adaptive function to stressful events, although, exactly how the adaptive function or functions work is yet to be determined.

This chapter has determined that traumatic nightmares serve an adaptive function to stress or trauma and that the

nightmare is a natural part of the integration and healing process (Greenberg & van der Kolk, 1987). It follows, then, that there may be therapeutic value in working with traumatic nightmares just as there is value for the survivor in working with waking thoughts and memories of the trauma. Working on and facing the nightmare may increase a sense of active mastery and decrease avoidant behavior. The next chapter will explore methods of working with traumatic nightmares to aid in the post-traumatic healing process.

CHAPTER 3

WORKING WITH POST-TRAUMATIC NIGHTMARES IN COUNSELLING

This chapter will review the literature on direct psychological treatments of post-traumatic nightmares. Methods of working with nightmares within group and individual counselling sessions will be presented (see Appendix A for a synopsis of these methods). It is hoped that the step-by-step instructions for dreamwork outlined in this chapter will enable counsellors to facilitate nightmare work with clients thereby offering them another opportunity to work through their traumatic experience.

According to Mallon (1987), one of the most important aspects of therapy is sharing with another person that which has been hidden - making the private public, bringing worries into the open. This happens when we talk about our dreams and nightmares. However, many counsellors and clients fear or shy away from working with dreams and nightmares. Some clients find nightmares too threatening. Some counsellors may express their ambivalence about short-term treatment or deeper levels of intimacy by failing to find a way to integrate dream work into a short-term treatment approach (Hersh & Taub-Bynum, 1985), while others question whether dream work can be dangerous. In answer to this question, Ullman & Zimmerman (1979) state that there is no danger in

dream work as long as the person who intervens remembers that the dreams are the property and responsibility of the dreamer. Further, they suggest that:

> Whatever danger there may be is not around dream work per se, regardless of the depth or seriousness of its pursuit, but rather in the manner in which it is carried out. If theoretical formulations take precedence over a dreamer's felt response and if they are offered in an authoritarian manner, then a dreamer can be hurt. Our dreams are available to clarify what we are already experiencing. By becoming more known to ourselves we become stronger, not weaker. It is not dangerous to work with dreams. It may be dangerous not to (Ullman & Zimmerman, 1979, p. 32).

When speaking of nightmares, Morris (1985) states: "...at the place of our greatest fear lies our power" (p.214). Morris believes, as does Faraday (1972), that nightmares are potentially very useful dreams that provide the ideal arena in which to work <u>past</u> fear because they are ultimately safe. That is, in the dream we cannot be physically harmed and our psyches prevent us from delving deeper into a dream than we can handle. Morris also suggests that experiencing our fear in our dreams can enable us to become more fearless in our waking life.

In chapter one it was stated that nightmares often are not worked with in the very immediate period after a trauma as there are too many other needs that require immediate attention. However, Hartmann (1984) suggests that post-traumatic nightmares do respond to treatment and treatment should be initiated quickly. Failure to pay attention to the onset of nightmares early, according to Hartmann, may lead

to the client's "suffering from chronic Post-traumatic Stress Disorder (PTSD) with chronic nightmares, a condition much more difficult to treat" (Hartmann, 1984, p. 239-240).

Many treatments have been tried for chronic post-traumatic nightmares, but there is no agreement at present as to what is the best treatment. Supportive individual psychotherapy, group psychotherapy, and family therapy are all sometimes used. All these have occasionally, but not routinely, been reported to be successful. In addition, a number of medications have been used and sometimes have been found to be helpful in eliminating nightmares. These include the benzodiazepines, the tricyclic antidepressants (especially monoamine oxydase inhibitors such as phenelzine), imipramine, neuroleptics (particularily chlorpromazine), cyproheptadine, propranolol, the antipsychotics, lithium, and L-tryptophan or an anti-epileptic mediation (Burstein, 1984; Friedman, 1988; Frierson & Lippman, 1987; Harsch, 1986; Mellman & Davis, 1985; van der Kolk, 1987 and Walker, 1982).

From the above list of drug treatments it is apparent that there is no standard medication regularily used for traumatic nightmares. It should also be noted that there have been no well-controlled studies concerning the pharmacological treatment of nightmares (Fairbank & Nicolson, 1987 Halliday, 1987 and Hartmann, 1984).

In addition, some drugs may even defeat the purpose for which they are being used (ie: for eliminating nightmares). Hartman (1984) states that large doses of medication such as

tranquilizers may reduce anxiety and reduce the immediate intensity of the nightmares but may make the connecting process more difficult, by reducing REM-sleep, thus making the traumatic nightmares more likely to become chronic. For example, phenelzine inhibits REM sleep and when discontinued there is an increase in nightly REM sleep time and traumatic nightmares recurr. As well, some drugs such as benzodiazepines can produce ordinary nightmares as a side effect making them a poor choice as treatment because they replace one type of nightmare with another.

Hypnosis is another method that has been used and has been reported to be effective in working with traumatic nightmares and flashbacks (Cooperman & Schafer, 1983; Eichelman, 1985; Hall, 1984; Halliday, 1987; MacHovec, 1985; Seif, 1985 and Spiegel, Hunt & Dondershine,1988). Brief hypnosis was used initially for tension reduction with post-hypnotic suggestion for relaxation but subsequently, post-hypnotic suggestion and hypnotic regression have been used to recall and revivify the traumatic event, vent emotions, and gradually re-integrate the experience with improved coping skills (MacHovec, 1985).

Several researchers (Belicki & Belicki, 1986; Spiegel, Hunt, Dondershine, 1988 and Stutman & Bliss, 1985) have found that individuals with PTSD and frequent nightmares have significantly higher hypnotizability scores than control groups. They conclude that these findings imply an important role for hypnotizability in the genesis of PTSD and that

dissociative phenomena are mobilized as defenses both during and after traumatic experiences. These findings also suggest that trauma survivors are good candiates for hypnosis and hypnosis may be an effective aid in decreasing trauma induced nightmares.

While hypnosis has been found to be effective in treating individuals experiencing intrusive traumatic images (Halliday, 1987 and MacHovec, 1985), this chapter will focus on techniques that require little training and can easily be integrated into a counsellor's existing repertoire of counselling skills. Since hypnosis requires some specialized training it will not be described in further detail. However, those counsellors willing and interested to undertake training in hypnotherapy to help them aid trauma survivors are encouraged to do so.

Before presenting a detailed description of the various methods of working with traumatic nightmares, a review of the research studies on direct treatment of traumatic nightmares will be discussed. "Direct treatment" is meant to include therapies that work directly with the content of the nightmares or the nightmare process. It should be noted that there are few studies specifically focusing on treatment of traumatic nightmares and most of the research to date has been on ordinary recurring nightmares. It should also be recognized that much of the research reported consists of individual case studies, although there are some controlled and group studies.

Much of the research on direct psychological treatment of nightmares presented here is also reported in an excellent article by Halliday (1987). The following overview of the research studies will include behavioral methods (such as desensitization, implosive therapy, and flooding), cognitive interventions, relaxation techniques, story line alterations, and "face and conquer" methods. Halliday (1987) states that these approaches were all found to be helpful for some individuals.

Overview Of The Direct Treatment Research Studies

Desensitization and Behavioral Studies

Desensitization as a treatment for nightmares has been studied by Cautela (1968); Cavior & Deutsch (1975); Celluccui & Lawrence (1978); Geer & Silverman (1967); Miller & Dipilato (1983) and Schindler (1980). The general method of these desensitization studies was to identify the fear-generating components of the nightmares and then desensitize the dreamer to these elements. "Desensitization" was accomplished in a number of different ways (e.g.: by telling the client to relax, by the use of deep muscle relaxation and by the use of pleasant imagery) both with and without the use of formal fear hierarchies. In "systematic desensitization" a state of relaxation is repeatedly paired with brief presentations of anxiety provoking circumstances that are introduced in a gradual manner. These variations did not

appear to have different treatment results. A brief discription of these research findings follows.

Geer & Silverman (1967) provided the first published report of the successful treatment of a recurrent nightmare of a man who for 15 years had had a nightmare of being attacked. They used a modified version of systematic desensitization that involved a six-item hierachy constructed from successive parts of the dream of the violent attack. The treatment included 5 sessions of training in muscular relaxation followed by 7 sessions of rehearsing successive parts of the dream in temporal order. The frequency of nightmares diminished only after the third rehearsal session, when the patient was instructed to say when anxious "Its just a dream" and then to continue the image. The client reported that the dream disappeared and therapy was terminated after a total of 13 contacts.

Cautela (1968) employed short term desensitization with successful results in treating 3 subjects with recurring nightmares. In one case, the nightmare involved the dreamer/client being chased by a man. In counseling, the client was asked to relax and then imagine that she was dreaming certain parts of the nightmare starting with the the first part of the dream (that she was walking down the street). When she could do this without experiencing anxiety, she was instructed to signal by raising her finger and she proceeded to the next part of the dream. After the second presentation of the nightmare in this manner, the

client was asked to imagine the entire dream and to report whenever she felt anxiety, at which time she was told to relax and try to imagine the scene again. The scene was repeated until it could be experienced in imagination without anxiety. After the whole dream could be imagined while the client felt relaxed, she was instructed to practice the procedure twice a day at home. In 3 days the nightmare disappeared and their was no recurrence during the 18 month follow-up. Cautela (1968) also reports that "similiar" results were obtained with 2 other clients but details are not provided.

In another study, Cavior & Deutsch (1975) report that they used hierarchical desensitization with relaxation to reduce anxiety produced by recurrent traumatic nightmare involving the client's father killing his mother. The client, a 16 year old incarcerated male, was first taught a standard relaxation technique. The client's dream was divided into 12 hierarchical imaginal scenes. Following initial relaxation, each scene was sequentially introduced and followed by the therapist's suggestion that the subject was still very relaxed. After 3 sessions with the therapist and several practice sessions by himself, the subject reported no further anxiety to the dream (which continued to occur). These results, with the continued occurrence of the nightmare, suggest that the problem has been only supperficially dealt with and that the trauma has yet to be fully worked through and integrated.

Schindler (1980) also used hierarchical desensitization and relaxation in the treatment of a Vietnam War Veteran with a recurring traumatic nightmare of a gruesome mine explosion. Therapy consisted of traditional systematic desensitization with a graduated seven stage heirarchy constructed from the anxiety-eliciting cues in the chronological progression of the events of the dream. As well, a progressive relaxation technique was employed that required the subject's selecting and imagining a pleasant scene. Self-administered desensitization at home was also encouraged and carried out. After 6 sessions of desensitization with an additional self-control procedure, the dream ceased to occur and anxiety about sleeping diminished.

In contrast to the above mentioned case studies, Celluccui & Lawrence (1978) present a controlled group study of 3 groups of students who averaged two to three nightmares per week over an unspecified period of time. Twenty nine subjects were assigned to either desensitization, a discussion placebo or continuous self-monitoring group. The two treatment groups (desensitization or discussion placebo) were seen in 5 individual sessions. Subjects in the desensitization group were trained in relaxation and had individually conducted hierarchies for disturbing nightmare images. Scenes were briefly visualized while the subject was told to relax. Two cognitive elements of having the subjects imagine coping with the situation and saying to themselves. "It's only a dream" were also employed. The discussion group

consisted of nondirective discussion of the nightmares and how they might be related to current and past events. The control group engaged in continuous self-recording of nightmares and other sleep variables.

Results for the desensitization group showed a significantly greater reduction in the frequency of nightmares as well as a decrease in rated intensity. Further, Cellucui & Lawrence (1978) report that there did not appear to be a difference in the effectiveness of the treatment between subjects whose nightmares related to previous events in their lives (eg. rape, death of loved one) and those subjects whose nightmares (being attached, murdered) were "presumably learned via vicarious conditioning".

Miller & DiPilato (1983) also compared 3 groups of nightmare sufferers. Subjects were randomly assigned to: (a) a relaxation training group; (b) a systematic desensitization group; or, (c) a waiting list control group. The relaxation group received six sessions consisting of standardized muscle tensing/relaxation instructions as well as directions in the use of imagery, cue words, and breathig exercises. Home practise was encouraged, recorded and rated as to relaxation level. The desensitization group received the same six sessions of relaxation training, but in addition they received formal systematic desensitization with hierarchy construction focusing on dream content. Dream scenes and elements from the dream scene were arranged in order of

subjective units of distress rather than in ordinary temporal sequence. Subjects practiced and recorded relaxation and hierarchy exposure exercises at home. At the end of 15 weeks, the two treated groups showed significantly greater decreases in nightmare frequency than the control group, while the two treatment groups were not significantly different from each other. However, they reported that desensitization showed a modest advantage over relaxation treatment at long-term follow-up in reducing the intensity of nightmares when they did occur, although relaxation alone was equally effective in reducing nightmare frequency. This study, then, emphasizes the effectiveness of relaxation per se in reducing nightmares.

Other behavioral techniques (implosive therapy and flooding) have also been reported to have successful outcomes with decreasing nightmares and will now be described.

Flooding is a respondent conditioning technique in which extinction is achieved by continuously confronting the anxiety-producing stimuli. The therapist narrates a detailed image incorporating the client's images and associated feelings. The rationale is that if the client is literally flooded with anxiety-provoking cues, the client will discover there is no basis for fear.

Implosive therapy is behavior modification technique that is quite similar to flooding and is used to extinguish anxiety through imagining fear-producing situations and holding the anxiety at this pitch until anxiety extinguishes.

It is based on the theoretical principle that if the client continues to repeat a response without reinforcement, the strength of the tendency to perform that response will progressively diminish. The procedure requires the client to experience a full measure of anxiety and to discover that the basis of the fear is groundless. Implosive therapy and flooding forgo relaxation and even heighten anxiety by their use of continued exposure. Following the theory of implosive and flooding procedures, then, continuous and intense presentation of nightmare stimuli would result in extinction of the physiological arousal associated with these images, thereby reducing the frequency and/or intensity of nightmares.

Haynes & Mooney (1975) reported the successful use of implosive therapy in treating 4 female students related to rape, physical aggression and rejection. Implosive therapy sessions involved vivid descriptions by the therapist of nightmare themes such as being raped, knifed or totally rejected by parents. The students reported elimination or substantial reduction in frequency and intensity of nightmares.

Grigsby (1987) also used an implosive technique to decrease a Vietnam Veteran's re-experiencing of combat imagery. The client was asked to close his eyes and imagine himself in a particular combat situation that he had just been describing in a very detached, affectless manner. He was asked to make the image as vivid as he could, noting the

sounds, sights, and smells and particularly noticing what he was feeling at the time. This imagery technique was repeated three time in each session. After each trial they discussed what had gone on. With every repetition of the exercise, the client recalled more detail from the incident, and his feelings became more intense. When the client had clearly been experiencing strong affect from recall of an incident, Grigsby would suggest to the client that he imagine a different outcome in order to clarify other facets of his emotional response. After 10 sessions Grigsby reported that the PTSD was essentially resolved and the client no longer had intrusive recollections of combat experiences.

Grigsby (1987) did not use relaxation as part of the treatment procedure. The client was asked to allow the scene to develop spontaneously and the imagery technique was introduced into the therapy session at appropriate times in the context of subject matter brought up by the patient. However, Grigsby suggests that one trial of imagery is usually not enough and it is necessary to have the client go through imagining many different scenes, several times each before s/he can fully resolve these issues. Further, Grigsby states that his implosive technique is somewhat like "guided imagery", although the starting point is always in the memory of an actual experience.

In another report, Keane & Kaloupek (1982) describe the treatment of a 36 year old Vietnam Veteran by the exposure technique of imaginal flooding using the intrusive thoughts

(nightmares and flashbacks) associated with the traumatic event. The presentation of a scene was preceded by 10 minutes of relaxation. A scene began by instructing the client to imagine the weather conditions, terrain, the specific locale, the accompanying individuals, and the client's emotional state prior to the occurence of the trauma. The details of the event were then slowly and gradually presented by the therapist, who regularily elicited feedback from the client regarding the next chronological event in the sequence. When the client became visibly anxious, he was encouraged to retain the image as long as possible until it was no longer anxiety provoking. All scenes were concluded by eliciting the events and emotions associated with the time immediately following the trauma. Keane & Kaloupek found that the reduction of anxiety through imaginal exposure to the aversive events lead to marked improvement in nightmare anxiety and in overall adjustment.

Fairbank & Keane (1982) also used imaginal flooding as the treatment for 2 Vietnam veterans with recurring nightmares and flashbacks. One scene was presented for imaginal flooding during each daily treatment session. Each scene was present for flooding only once. Sequence of scene presentation was randomly selected. They report that subjects reported considerable anxiety reduction following each session.

The above mentioned studies, by their demonstrated therapeutic effectiveness, give support for the behavioral

contention that nightmares are responsive to reinforcement and extinction. Some suggest that exposure of the fear producing images in the therapeutic situation may be an important factor in reducing nightmare frequencies in various therapies. For example, Fairbank & Nicholson (1987) examined the treatment procedures employed (Dynamic, behavioral, biochemical) in available studies and revealed that direct therapeutic exposure to the memories of trauma emerged as the PTSD treatment technique common to all three theoretical models. Thus, regardless of the underlying theorectical rationale, each of the foregoing treatments has involved directly exposing the client, in the context of a stable therapeutic relationship, to the feared traumatic memories. It appears, then, that direct therapeutic exposure to the trauma has emerged as the single most important factor in the treatment of PTSD.

Behavioral approaches have both advantages and disadvantages within the counselling session. The advantages are: (1) they are relatively well standardized and methodologically clear; (2) they are the only psychological treatment method so far with demonstarated effectiveness in controlled experiments; and, (3) no symptom substitution has been reported in these studies (Halliday, 1987, p. 514). In fact an increase in self-confidence and reduced fearfulness during the day (as well as less anxiety over sleep and dreaming) was noted with the subjects in some studies (Cavior & Deutsch, 1975; Johnsgard, 1969; Kellerman, 1979 and Wile,

1934).

Disadvantages of the clinicial use of desensitization and behavioral techniques include: (1) these results may not generalize to more disturbed groups; (2) nightmare distress refers to discomfort both while asleep and while awake, which may require two separate interventions (e.g.: the need to add cognitive interventions like "It's only a dream"); and, (3) some people cannot visualize the feared object at all. Some people can visualize the feared object, but immediately panic (respond not at all or panic) and appropriate hierarchies cannot be constructed. A fourth disadvantage is that of client or therapist refusal to use desensitization, believing it to be either too boring to be endured or irrelevant. Finally, clinical skill may be called for in presenting relaxation (Halliday, 1987, p. 514).

Cognitive Interventions

Cognitive interventions involve methods for reducing the perceived importance and realism of nightmares. Examples of these methods include Geer & Silverman's (1967) training their client to repeat to himself "It's only a dream" and the use of that phrase in the desensitization group in Cellucci & Lawrence's (1978) study. Although both of these studies were designed to measure the use of desensitization or behavioral techniques, it was noted by Geer & Silverman (1967) (and mentioned earlier here) that positive results occurred only after the client began to instruct himself, "It's only a

dream" thereby learning to discriminate that this event was not reality. Similarily, Faraday (1972, p. 296) has also controlled frightening nightmares by the use of the phrase "You have no power over me" thus reducing the perceived realism and importance of nightmares.

To this date, cognitive techniques have been reported to be successful in eliminating nightmares. These techniques are simple and easy to use for those suffering from nightmares. However, those studies reported are case reports and there are no experimentally controlled studies published. Thus, research is needed to determine the therapeutic value of cognitive interventions.

Story Line Alteration

This method involves altering the anxiety provoking story line itself through rehearsal of different endings to the nightmare during the waking state (Bishay, 1985 and Marks, 1978), confrontation of nightmare figures in the awake state (Johnsgard, 1969), and alteration of a dream detail in the awake state (Halliday, 1982).

Marks (1978) used repeated rehearsal of a recurring (every three months since 1963) nightmare in treatment. The client was encouraged to relate the nightmare three times, all three accounts together totalling no more than 20 minutes. Each rehearsal evoked intense crying and emotion although the affect was less on the third occasion. The client was encouraged to write a description of the nightmare

and to try to rehearse triumphant endings. Total treatment time was three hours and the nightmare had not returned at the time of a 16 months follow-up. Marks suggests three possible therapeutic components of this method; exposure, abreaction and mastery (the introduction of a triumphant ending).

Bishay (1985) also used rehearsal with an altered ending in treating seven clients with recurring nightmares. In all cases alteration of the ending of the nightmare, whether to one that was triumphant, happy or neutral, was followed by marked improvement, but the triumphant ending seemed to be the most therapeutically effective.

Also, Bishay (1985) reports that in four cases the clients dealt with the threatening elements in the nightmare by eliminating it as soon as it appeared <u>without</u> proper rehearsal of the contents of the nightmare. She concluded that the effectiveness of such an approach suggests that exposure and abreaction (suggested by Marks, 1978) are of secondary importance in the treatment of nightmares and that elimination of the threat arising from the content of the nightmare is the most important therapeutic factor.

Johnsgard (1969) used a technique (symbol confrontation) related to Jung's (1974) active imagination technique. The client is first asked to describe the dream clearly to the therapist so that the content is fully understood. The client is then asked to make her/himself comfortable and when relaxed is asked to attempt to bring the dream into the

present and to re-experience it. S/he is asked to make the dream a "here and now" experience, and is instructed to begin by attempting to visualize and carefully describe the situation (objects, scene, people, action, feelings) in the earliest stages of the dream recalled. Instead of running from the pursuer in the dream, in the re-creation, the client is encouraged to stand her/his ground and confront the symbol in a progressively positive fashion. If the client is too frightened it is helpful to take a bit of time and ask for a careful description of the symbol and its behavior while carefully inquiring about the client's feelings. Johnsgard concluded that symbol confrontation is a very powerful tool which almost always tends to produce some positive results with nightmares.

Halliday (1982) presented a brief case study of a young male farm worker who suffered recurrent nightmares subsequent to being run over by a tractor. The client was first made aware that the nightmare could be changed while dreaming it. The key was to make the initial change very small and of little emotional significance and then to gradually work up to bigger changes. That is, gradually to shape the dream behvior from a nightmare to a more acceptable dream. The nightmare was effectively eliminated after the client recognized he was dreaming, that is, at the point at which the nightmare became "lucid" (La-Berge, 1985) and was able to change an insignificant object in the dream.

Wile (1934) also used cognitive interventions as he

attempted to eliminate nightmares in a group of twenty-five normal children who were suffering with post-traumatic nightmares. Some of these children were asked to choose something they would prefer to dream about, such as visiting children in different lands; others were told that their nightmare was foolish and to tell themselves they would sleep peacefully all night; still others were taken to do things relevant to their nightmares. For example, one child had been frightfully awakened in the middle of the night by fire alarms and bells when the house across the street from his caught on fire; he was troubled thereafter with terrible dreams of fire engines. He was taken to visit a fire engine station, where he talked with the firemen about their job and the engine. All the children were eventually able to eliminate their nightmares, but those who engaged in relevant activity in waking life were, as a group, quicker to have their nightmares disappear (on the average, within two months). Those children who suggested pleasant substitute dreams to themselves averaged three months before the nightmares vanished, and those who were given suggestions to ignore the nightmares averaged five months before they disappeared. Thus, it appears from this study that planned coping activities were more efficient in reducing nightmares than the other two cognitive methods. Halliday (1987), though, suggested that this conclusion may be premature, particularily given the small size of the mastery group (N=3).

Some advantages of the dream alteration tehcniques (Halliday, 1987,) include: (1) Brevity - In these reports, the therapeutic intervention was 3 hours or one or two therapy sessions (desensitization, in contrast, appears to require more sessions), and (2) the alteration techniques can be used as comfortably with traumatic as nontraumatic nightmares. Disadvantages or limitations include that not all clients have control over their waking imagery, and for such persons these methods may not be appropriate.

Face and Conquer Studies

The face and conquer method requires that the dreamer confront and fight the feared object in their dream while they are dreaming. Facing and conquering the feared object during the nightmare not only alters the story line but also increases feelings of control. This method may require that the dreamer have some degree of lucidity (awareness during the nightmare itself that one is dreaming) or that the dreamer "program" her/himself just before sleep onset, with a command that should the nightmare occur s/he will confront and conquer the feared image.

Halliday (1987) stated that face and conquer techniques are used extensively in clinical settings in part because of well-regarded books by Garfield (1974) and Faraday (1974). However, Halliday also stated that the primary empirical justification for the use of these techniques have been refuted. While a few case studies using these and similar

methods have been reported (Faraday, 1974; Garfield, 1974 and Murray & Murray, 1978), the primary justification has been Kilton Stewart's report of the dream techniques of the Senoi, a primitive Malaysian people. These people were said to exercise control over their dreams and to rarely experience nightmares because they were trained to stand their ground and confront the aggressors in their dreams. However, as Tart (1979) noted, the Senoi as described by Stewart sounded too idyllic to be true and Halliday (1987) reported that recent investigators have confirmed this suspicion.

Doyle's (1984) study, although not aimed specifically at nightmares, is relevant here. She described a complex training strategy which significantly increased dream pleasure and reduced dream displeasure. One part of this training strategy included a seven-step Senoi dream work procedure. She found that Senoi Dreamwork was considered the most useful of the intervention skills learned and was described by dreamers as giving a sense of mastery in influencing dream outcome.

Regardless of whether or not the Senoi people ever practiced Senoi Dreamwork, many therapist state that the Senoi principles are helpful in working with nightmares (Faraday, 1974; Garfield, 1974; Greenleaf, 1973; Herod & Smith, 1982; Morris, 1985; Wallis, 1980; and Williams, 1980). However, empirical research is necessary in order to determine the therapeutic value of the Senoi principles and the face and conquer method of working with nightmares.

Advantages of the face and conquer methods are that: (1) they change the nightmares during the actual dream, rather than at some later time; (2) they can result in significantly increased feelings of control, which may have beneficial effects in the nondream life as well; and, (3)the experience of lucid dreaming is well documented for both the at-home and the sleep lab condition (Gackenbach, 1985; La-Berge, 1985; La-Berge, Nagel, Dement & Zarcone, 1981 and Wolman, 1979). Disadvantages of this method include that it is not known how to reliably induce the lucid dream experience (Gackenbach, 1985 La-Berge, 1985) or if it is possible for everyone.

Conclusion

The Research presented here gives support for the value of the psychological treatment of nightmares. However, much of the research available, involved case studies and only two controlled studies on the direct treatment of nightmares were found (those by Cellucci & Lawrence, 1978 and Miller & DiPilato, 1983) and their experimental groups were small. Although all of the above mentioned methods of direct treatment of nightmares were found to be successful with some clients, further research is needed in order to determine which methods are best used with traumatic nightmares for the best therapeutic results.

Dreamwork Methods

The following is a step-by-step outline of a few methods that have been found by some dreamworkers to be helpful and easily incorporated by the generalist counsellor into her/his repertoire of counselling skills. Methods of working with the nightmare in waking and dreaming states will be presented.

Some methods presented here will have more appeal or seem more productive than others. Some counsellors may even find themselves using more than one technique with a single nightmare. Also, some techniques feel safer to many people. For example, dream re-entries can bring up fearful things as well as feelings of being overwhelmed and various strong emotions. Counsellors should do only what they and their clients feel safe with and risk more as they become grounded in what they are doing.

It is important that counsellors decribe the dreamwork techniques to the client in detail before dreamwork is undertaken. This will enable the client to make an informed decision as to whether or not s/he wants to become involved in dreamwork and the type of technique(s) s/he would prefer to work with. The goal is to create a balance - providing enough information to increase client options while being cautious not to overwhelm the client with too much information.

Before undertaking dreamwork, it may also be helpful to discuss with the client, the use of a dream journal. A dream journal is a diary of one's inner journey, a record of one's

progress in problem-solving and an indicator of areas where problems still exist (Morris, 1985). Usually, a dream journal is kept because dreams are easily forgotten and recording them upon awakening is essential in order to work on the dream. This is not the case with traumatic nightmares as they are usually easily remembered. However, keeping a journal of the nightmare will allow the dreamer to keep track of how often the nightmare occurs, if there are changes in the content of the nightmares, the effects of waking life events on the frequency of nightmares and to evaluate the use of dreamwork methods.

There are a number of ways to organize the dreamwork journal (Faraday, 1974; Garfield, 1974; Morris, 1985; Taylor, 1983; and Williams, 1980). One structure is always to write the date, and dream, on the left-hand page and then use the right-hand page for doing dreamwork. Whether you do dreamwork right after recording the dream or later, the right-hand page is left blank for the dreamwork and evaluation. Also, if dreamwork is not done with a particular dream, lifework may be put in its place. The basic divisions of the dreamwork journal are as follows:

Left-hand page:	Right-hand page:
Date	Dreamwork Method
Recorded Dream	Dreamwork
	Evaluation

The evaluation is usually a free-flowing summary of what

you have gained from the dreamwork. It is often important to add a specific commitment to carry out the meaning of the dreamwork in your daily life. Lifework is any nondreamwork journal work which may or may not be related to a specific nightmare.

Individual Counselling Techniques

Rehearsal Method

A good place to begin (for inexperienced dreamwork counsellors) is with the rehearsal method of working with nightmares. Some clients will benefit from simply rehearsing or sharing the traumatic nightmare in detail with the counsellor (Amen, 1985; Hartmann, 1984 and Natterson, 1980) and will neither require nor request further help with the nightmare.

Rehearsal is the type of psychotherapy sometimes called abreaction or ventilation. The main focus is to allow the trauma and its associations to become conscious and incorported into the totality of the person's mental life (Hartmann, 1984). The client is asked to retell the nightmare and the frightening events during waking in a variety of ways- recalling, re-living the emotions associated with the trauma and connecting them to times when similar emotions occurred. The counsellor can try to understand what made the situation especially traumatic and provide understanding and support, as well as opportunity to re-

experience the emotions and make connections in a safe setting.

Key Questions:

Another method of working with nightmares that requires little practice is the Key Questions method. After hearing the nightmare in detail, the counsellor asks the client questions about the nightmare (or the client can take this list of questions home and do the work in private and discuss the work in further counselling sessions).

The list of questions given below will produce tentative responses and most likely they will lead to new questions. It is important to instruct clients to let their intuition have full rein by writing whatever comes up in responding to the questions. There are no right or wrong answers. Clients can respond to as many questions as they choose to respond to and some may choose one or two "key" questions. In selecting questions, it is helpful to go with the question that elicits the greatest postive or negative energy response.

The following is the list of Key Questions in responding to the nightmare. The list has been created by combining suggested questions for working with dreams from the works of Morris (1985); Toombs & Toombs (1985) and Williams (1980).

Key questions for responding to nightmares:

1. How am I acting in this nightmare?
2. What are the various feelings in this nightmare?

3. How do I feel about the nightmare?
4. What are the various actions in this nightmare?
5. Am I active or passive in the nightmare?
6. Who or what is the adversary in this nightmare?
7. What is being wounded in this nightmare?
8. What needs to be healed in this nightmare?
9. What would I like to avoid in this nightmare?
10. What choices can I, and will I, make as a result of working with this nightmare?
11. Why do I need this nightmare?
12. What is the nightmare drawing to my attention?
13. Why am I not dealing with this situation in this way?
14. Why am I not doing this in my life?
15. Why have I dreamed this nightmare now?
16. Where are my helpers/guides in life and in my dreams?
17. What can happen if I work actively with this nightmare?
18. What new questions come up from this dreamwork?

Re-living or Amplification of the Nightmare

Means, Palmatier, Wilson, Hickey, Hess-Homeier & Hickey (1986) present a step-by-step description of their process of re-living a dream and it appears to be adaptable to working with nightmares as well. Their approach is divided into four overall steps (examining the images, clarification of affective and kinesthetic components, revivification, integration) which entail going through the nightmare at least three times.

1. Examining the images - The counsellor begins by obtaining a verbatim account of the nightmare.
2. Clarification of Affective and Kinesthetic components - This step is designed to clarify and enrich the details. Of particular importance is the identification of feelings and kinesthetic sensations associated with the various images. The client is asked to provide further detail and identify and then organize the sequence of feelings, actions, and experiences in the nightmare. The general goal is to identify and then organize the sequence of feelings, actions, and experiences in the nightmare. The organized pattern of emotional and behavioral sequences serves as a "road map" to be followed during the revivification process.
3. Revivification - The evocation of feeling tones and affect is begun in earnest in order to obtaining full understanding of the nightmare. There are three stages:

Stage 1: Begin by telling the client that s/he will be better able to re-experience the nightmare after closing her/his eyes and relaxing. Relaxation instructions are then given.

Stage 2: Once relaxation has been achieved the counsellor instructs the client to re-live the dream. For example, "I want you to re-live the feelings you had in the nightmares. Focus your attention on the events of the nightmare as you re-live it now. Allow these events and experiences to return now". The counsellor then guides the client throught each segment, using the client's words to describe the visual

and affective experiences associated with the nightmare content. It is important, while reliving the dream, that the client use the pronouns "I" and stay in the present tense. Particular attention should be paid to any strong affects.

The counsellor proceeds by rebuilding the richly detailed picture of the nightmare scenes obtained from the client in the preceding steps. The counsellor may recall visual images, gestures, facial expressions, conversations, and any other information from the nightmare which will increase the experience for the client. All images are related to the client in the present tense with the intention of helping re-live the dream images.

Stage 3: Following the construction of a richly detailed image, the counsellor abstracts the essential feelings and striking images. These components of the nightmare are again related to the dreamer, in intensified form with emphasis on the affective. The pace of the focusing process is slow, in order to intensify affect. The counsellor can connect these experiences to other times or experiences by asking if the client has experienced similar sensations previously. The counsellor should also attend to postural or facial shifts, as cues that the client has moved on to the next image. The client is then asked whether these dream components and feelings sequences can be related to the client's current life situation.

4. Integration - The final step is the general therapeutic approach of integrating the client's new or reorganized understanding and insights related to the trauma. The process of re-living the nightmare is often deeply moving and often accompanied by expression of intense emotion of feeling (Williams, 1980). Therefore, it is essential that both counsellor and client feel comfortable, trust the process and not be fearful of the

expression of strong emotions.

Guided Re-entry into the Dream State

A key aspect of this approach is bringing resolution to the nightmare. The method emphasizes evoking new feeling and imagery which aids in the resolving or completing the original material. The task is to take the person back into their nightmare and support them while they deal with it.

The dreamer immerses her/himself back into the dream using re-visualizing of the dream and letting go to new imagery and sometimes dialogue. The intention of bringing resolution, healing or positive change is also usually taken into the dream. The dream events are described to a guide who also is in a meditative state and who asks questions and makes suggestions for activity as things proceed.

During the re-entry, the dreamer can change parts of the nightmare, or dialogue with others in the dream in order to evoke this healing/resolution. The dreamer can do anything s/he wants with the dream, including changing it to a pleasant one.

The dreamer is told at the beginning that s/he has free choice and does not have to do anything in the re-entry that seems too scary or inappropriate. This cannot be emphasized enough. The re-dreamer must keep in touch with the power of choice and let go to the healing process in the unconscious. The guide is only a supporter, not a determiner of the process.

The counsellor/guide's task in the guided re-entry, according to Williams (1980), is to become clear with the dreamer on her/his issues and intentions for the dream re-entry. The role requires great sensitivity and awareness of the client's experience. Knowing as much as possible about the client and the context of their life will enable the counsellor to guide the client in having the optimal experience with her/his nightmare.

In guided re-entry, then, the counsellor/guide works to aid development and resolution of the nightmare. Too directing a guide can intrude on the dreamer's own process. Such a guide may interject subjective material of her/his own. The counsellor should not try to put across her/his point of view but should be able to suggest an opposite or new element if the client seems blocked. However, the counsellor must always give the dreamer choice to take the suggestion or not (eg: "You have choice here. Would you like to do the following?"). The state for a guide to be in is one of open receptivity without an overly particular point of view. The overall point of view that is helpful is that of seeking involvment in and resolution to dream states.

In the guided re-entry process into the dream state, the client first tells the counsellor the nightmare in its entirety. Together the counsellor and client will look for the key issues in the nightmare and state them in the form of descriptive questions using the imagery of the nightmare whenever possible. Primarily the counsellor and client will

be looking for conflicts, actions or dialogues which are only begun in the nightmare and which might be valuable for continuing and bringing to resolution.

After developing the above, choose which issues and aspects of the nightmare the client needs most to deal with, and that s/he has the strength to deal with now. Note this as an intention for when the client has re-entered the nightmare.

Having formulated the client's intention for re-entering the dream the client now chooses the most relevant place to re-enter the nightmare. This may not be at the beginning and may not necessarily involve the whole dream but only certain scenes.

Next, in either a lying down or a sitting position the client is instructed to close her/his eyes and clear her/his mental space of external reality. For example,

> With your eyes closed let a place empty inside of you. It is your central area that you are clearing out, so it is simply empty of anything. Any distractions, any thoughts or anxieties from external reality, let these slide by, without invading your central space. Let, also, any internal feelings, images, anxieties fall aside so your central space is clear. Let your breathing be regular and let go to it. Let its energy clear out your central space with its rhythmic flow.
>
> Now that your space is empty and you are relaxed let the scene from you dream re-appear in that space. Focus in on the details and describe them to yourself. Let the dream figures be there. When it seems right let the action of the dream begin again, remembering the intention you have for this dream. Perhaps you or other characters will act differently or develop their actions more? Who knows? You are letting go. You are not fixed on your intention. You are letting go to it and

seeing what happens.

> What is happening now in your dream? Let go to the images and let them move and develop. Your intention is only part of the process. The dream itself is now alive for you as you let things happen. (Williams, 1980, p. 181-182)

Some clients may require more time than others to relax and get into a meditative state. In these instances the following deep relaxation exercise may help the client get the feeling of a dream state while awake. The counsellor may want to tape-record this exercise first and play it during the session. Since the purpose is to relax the client, the exercise should be spoken or recorded in a slow, soothing voice, with plenty of pauses.

> Close you eyes and sit with your legs uncrossed and your feet flat on the floor. Prepare yourself to take five deep breaths. You will inhale as deeply as you can, hold the breath for a count of five, then exhale as completely as you can...Inhale...one, two, three, four, five, exhale....Inhale...one, two, three, four, five, exhale...Inhale , etc.
>
> Feel your body get heavier and heavier...Feel yourself sinking deeper and deeper into the chair...Let your mind relax and go... Know that your mind contains all the imagery and answers you will ever need...
>
> Now feel yourself floating, on an air mattress in a calm sea...Floating and drifting, floating and drifting, floating and drifting...Let go of the conscious control of your mind and allow your unconscious to take over... Know there is great freedom when you intuition takes charge; spontaneous and innovative ideas appear...Let them come forth...Then let them go...
>
> As you float, your body becomes more and more relaxed... Your muscles become slack and heavy, slack and heavy... Your breathing slows down...Your heart rate slows down... Your body winds down and down...Starting with y our head, feel your scalp and forehead relax and expand...The warm relaxation

> spreads down your cheeks...into your jaw; let your mouth drop open...The warm, heavy feeling extends to your shoulders, pulling them down...and into your arms... and your hands...and all of your fingers...All feeling relaxed, and warm and easy...
>
> The easy warmth spreads down through your chest...relaxing your diaphragm...Breathe slowly, evenly, easily...Feel you back relax, expand...Sink down into the floating air mattress
>
> ...Feel the relaxation move down into your thighs...your knees...your calves...your toes... All relaxing, expanding, warm...
>
> As you float, your mind drifts...Everything around you disappears, even the sound of this tape...Your free, spontaneous mind takes over and everything else disappears....
>
> Let your mind go...float...drift...(Morris, 1985, p. 183- 184).

The counsellor/guide is to immerse into the same meditative state as the client/dreamer (Williams, 1980).

Morris (1985) suggested that once the client is in a meditative state and begins to retell the nightmare, that it is up to the counsellor to direct the dreamer, asking an occasional question, such as: What are you feeling now? How would you change that aspect of the dream? Does the dream remind you of anything else besides the original trauma? How would you like to deal with the frightening person/situation/image? The counsellor can also suggest dream tasks like recreating the ending or invite a supportive person in to help.

Let the dream continue until a natural resolution develops or until the client chooses to stop the process. At some point the dreamer will usually feel a resolution occuring, or at least a stopping place wherein the available

energy has been pretty well used up. If resolution or ending does not seem to be occurring the counsellor might ask, "Does it feel like things are coming to a conclusion for now? or "What resolution can be made at this point?"

After slowly coming out of the meditative state the counsellor and client should share some of what they have experienced. The counsellor should not interpret but you may want to suggest simple questions to focus with. As well, after the re-entry the client may choose to process the experience on her/his own using the dreamwork journal or may choose to process the experience further within the counselling session. The dreamwork can be continued by helping the client make her/himself really aware of the feelings and emotions aroused by the re-entry (anxiety? fear? guilt? gratitude?); by deciding what waking life tasks the client might do to actualize the insights and values gained from the dream re-enty; and/or by choosing what personality dynamics and attitudes need changing based on this dreamwork?

For an excellent example of guided re-entry with a traumatic nightmare and further discussion of dreamwork re-entry see Williams (1980, p. 187-189).

Re-entry into the dream state can be a powerful experience which could possibly have harmful as well as healing effects (Williams, 1980). Examples of actions which might have harmful effects are:

1) Leaving the person stuck in an emotional conflict which the re-experiencing of the dream got them back into. The way out is to keep working for some healing resolution.

2) Taking a position for or against some situation in the dream since this closes down rather than opens up the possibilities. There are choices to be made within the re-entry and there is possibility of resolution. Resolution is evoking a unity which brings opposites together.

3) The guide's projecting her/his unsolved problems into the other person's situation.

It is important that the counsellor be fully aware of the dreamwork re-entry process and how it works. Williams (1980) suggested that the counsellor should have past experience in self-re-entry before attempting to guide another dreamer through the process. Self-re-entry involves the same process as the guided re-entry process. The dreamer immerses her/himself in the dream through re-visualizing it and letting go to the imagery and dialogue. The intension for resolution is also present. However, there is no guide and the results are written down afterwards or the re-entry experience can be described into a tape recorder.

Besides the guided re-entry and the self-re-entry methods, Williams (1980) also offers the following suggestions for working with nightmares:

1) First record your nightmare even if you do not want to.

2) Next, you might choose to write all the feelings you are experiencing immediately as a result of the nightmare.

3) Or, immediately after recording your nightmare, you may choose to re-enter the nightmare further with the adversarial forces, thus;

-either visualize the nightmare again and keep your dream ego in the situation past the point at which you woke yourself up, and see what happens; or,

-visualize the dream again and do or evoke some healing action. Befriend or dialogue the adversary and find out what it wants. You might also re-enter the nightmare taking with you some healing symbol such as a lit candle or a protector-guide, and let the dream continue.

4) If you choose not to re-enter the nightmare on your own, you may want to ask someone you trust to guide you into it again and continue with it and seek resolution. Caution may be needed by all parties involved.

5) You may also choose to simply re-write the nightmare consciously, emodying more courage, relation, healing and working towards resolution. Elements needing change or resolution are analyzed and creative, meaningful resolutions chosen. The nightmare is then re-written imaginatively within the context of the changes desired.

6) You may decide to use the method of four quadrants which involves dividing a paper into four quadrants. The nightmare is drawn in three acts. In the fourth quadrant, imagine and draw a resolution.

7) A dialogue with the nightmare characters or with the major emotion in the nightmare may be another technique you might chose. Dialogue continues until resolution occurs.

8) Finally, the dream changing method may be the technique of choice. Using work you have done on this dream, decide on changes you would like in future dreams: more assertion, more acceptance, more resolution, etc. Go into sleep carrying this intention for your dream. Williams (1980) cautioned dreamers not to create superficial resolutions. They should feel the conflict and then <u>allow</u> resolution. If the dream does not resolve, but remains in tension, that may be necessary also, as tension may be a necessary preparation for resolution.

When the dreamer chooses to use a journal for dreamwork instead of the counselling session, Williams (1980) suggested the following questions may be helpful:: What is unresolved in your original nightmare? What are some possible causes of this? What would be some meaningful resolutions to the issures raised in your nightmare? If you did a dream re-

entry, what new things developed for you? What resolutions came about? What was still left in tension? What new choices and changes in behavior will you attempt coming out of working with this nightmare? Create an intention you will attempt in future dream behavior should you have a nightmare again.

Senoi Method

Some writers suggest that the Senoi method is the ideal way to work with nightmares (Faraday, 1974; Garfield, 1974; Greenleaf, 1973; Herod & Smith, 1982; Morris, 1985; Murray & Murray, 1978; and Williams, 1980). This method of dreamwork allows resolution by taking contructive action within the actual drama of the dream (changing the actual content of the dream). By determining the course of her/his dreams the dreamer deals with problems and conflicts at an unconscious primitive and symbolic level (Greenleaf, 1973).

According to Garfield (1974), the effect of applying the Senoi system of dream control is to re-organize the dreamer's internal experience in such a way that her/his personality becomes unified. The results of unpleasant experience in waking life are at first neutralized in her/his dreams, then reversed.

Garfield (1974) outlines three of the general principles which the Senoi advocate for dream participation and mastery. First, the dreamer should always confront and conquer the enemy in her/his dream. The dreamer should never run away

from frightening dream images, but should hold her/his ground, advance upon the enemy, and attack. If the evil apparition is too powerful to defeat alone, then the person must call upon dream friends and allies to help her/him conquer the fiend. The dreamer must fight savagely to the death if necessary. At all times the dreamer must remember that s/he has the ability to bring about a positive outcome and a victory for her/himself. The death of an enemy is a good dream event. The destruction of an evil dream form causes it to reappear in a positive form, such as an ally or servant. Dream images are like the physical relationship of matter and energy. The images cannot be destroyed, they can simply be transformed and changed.

A second Senoi dream principle mentioned by Garfield (1974) is that the dreamer should bring about a positive and pleasurable outcome in the dream. Fears should be faced and unpleasant situations should be made pleasant.

The third principle is that no dream encounter or adventure should end until the dreamer asks for and acquires a gift from the enemy. Just as negative dream interactions are redefined in a positive and creative manner, they take on substance in the form of a gift. The gift also represents the power of the enemy and with the giving of the gift the enemy also gives over its power. The gift should be something useful to the dreamer in either a personal, symbolic or practical manner. Gifts may be poems, emblems, songs, dances or designs.

The Senoi believed in confronting adversaries rather than running from them. In any dream in which the dreamer finds her/himself the victim, that is, the recipient of any aggressive action-- the dreamer is to become reciprocally aggressive. The dreamer should attack her/his dream enemy and fight to the death. If necessary, the dreamer can call on dream friends to help, but s/he must fight by her/himself until they arrive. However, Williams (1980) does not go along with the Senoi contention that in confronting dream adversaries one should try and kill them. His view is that it is usually more productive and healing to relate to adversaries rather than kill them because there is something to be learned from the adversary.

Hammer (1967) takes a similar view that a dream image should only be confronted, not destroyed. He stated that to fight the image would be unrealistic because we do not know whether the client will be able to win the fight and fighting should be discouraged because it may be dangerous. Instead he suggested staring into the eyes of frightful dream image, overfeeding the dream enemy rendering it helpless, forcing it to perform an activity that exhausts it, or making friends with the hostile dream figure by petting it. Similarily, Faraday (1972) suggests that the dreamer resolve before going to sleep each night that if your pursuers appear, you will confront them with the challenge, "You have no power over me".

This author believes that clients who have survived a

trauma and are suffering from traumatic nightmares should be given a choice as to how they wish to approach the fearful images in their nightmares. Perhaps certain clients will need to try more than one way of confronting before successful resolution occurs. Thus, clients should be made aware of all confronting options mentioned here. As well, clients should be given the opportunity to design their own personal way of nightmare resolution through confronting their fear.

Four examples of the Senoi method will be described below: Herod & Smith (1982), Murray & Murray (1978), Carriere & Hart (1977) and Garfield (1974). Each example is based on the Senoi method, although only Murray & Murray (1978) and Garfield (1974) incorporate all of the three Senoi principles mentioned earlier.

In Herod & Smith's (1982) use of the Senoi method, the first step is for the client to describe the dream with as much detail and feeling as was in the original dream. Once s/he has done this, s/he is asked to identify the most important object or person in the dream and to visualize this person or object. Next s/he is to identify the emotion, and continuing, s/he is to see her/himself with this person or object. S/he is to distance her/himself until s/he felt safe. The person/object could be as close as touching or as far away as necessary.

At the point where s/he feels safe the dreamer is to give the significant person or the object of the dream a gift

which was a symbol of the dreamer's power. S/he could imaginatively produce some gift which symbolized her/his power over the other person or object in the dream. In turn the dream's significant person or object is to likewise give a gift to the dreamer which symbolized its power over the dreamer.

Carriere & Hart's (1977) method based on Senoi principles offers a format for dealing with a nightmare that has the following six steps:

1. Ask the client to embellish the dream. Ask her/him to tell it with feeling as if s/he were reliving the dream.

2. Next, ask the client to rethink the dream as if it were a movie. The movie is going to stop on one significant picture, one frame that is most significant of the whole dream. Once s/he has identified that picture ask, "How do you feel in this scene?"

3. Ask the client to contrast this significant picture with an event or scene which contains the opposite feeling or a feeling s/he would like to have. Embellish this scene and identify the feeling.

4. Ask her/him then to go back to the single frame picture and feeling which s/he had in the original dream. Proceed with - "remember when you felt this way in real life; see what you saw; hear what you heard; and feel what you felt as if you are experiencing this event all over again".

5. Next ask the client what is left out or what s/he could do or say that would make the real event turn out the way s/he wanted it to be.

6. This step is to look at the original dream picture and determine what could be done in the dream that would make it turn out the way the dreamer wanted it to be, i.e., make it turn out so that s/he feels the way s/he did in the contrast picture (Carriere & Hart, 1977, p. 161).

Murray & Murray (1978) state that Senoi dreamwork may be

broken down into three main stages: 1) Initiation and recontruction; 2) dialogue and confrontation; and 3) resolution.

Stage 1: Initiation and Reconstruction. The dreamwork begins with the therapist's asking the client to close her/his eyes and to indicate when s/he is in the dream. The dreamer is instructed to try to re-experience her/his dream in a sequential, unhurried manner and to report the dream in the active present tense. The therapist allows the dream to unfold at its own pace and stimulates the process by inquiring, "What is happening now?" It is essential that the dreamer remain as concrete and tangible as possible. If the client becomes obtuse and abstract, the therapist asks the dreamer to embody her/his feelings and impressions. How are her/his feelings presented in the dream? What does s/he see, hear, taste or smell? It is often helpful to ask for some description of the physcial details of the dream situation to aid in clarifying imagery.

The client should be told that the dream world is her/his own creation and that s/he has complete and absolute mastery of the dream. When the client shows resistance in the dreamwork, the therapist should trust the dreamer's wisdom and allow him to proceed on another course of action. The dreamer should be given as much autonomy and self-guidance as possible. If the client becomes bogged down in obsessive rumination and indecision, the therapist can facilitate the progress by employing positive double-bind

instruction. The therapist may say, "Take all the time you need and tell me when you have finished." If the client is indecisive regarding what action to take s/he may be instructed, "Do what you already know you need to do, and tell me when you have completed your action." If a piece of dreamwork would take a thousand years to complete, the therapist instructs the client "to begin the work and to let me know when a thousand years has passed."

The initial phase continues until the emergence of a dream motif around which significant conflict or interaction revolves. The central figure may take any form. Once the central figure emerges the efforts towards resolution and synthesis begin.

Stage 2: Dialogue and Confrontation. As the central or primary image emerges, the dreamer is able to take actions within her/his dreamwork which will allow for constructive psychological changes. The chief task is to establish contact with the main figure and bring about a dialog, a confrontation or whatever action is required.

If the dreamer is unable to clearly see the primary image, s/he may clarify her/his perception by establishing a new perspective. The therapist may suggest that the dreamer move closer to the image or farther away. S/he may wish to stand on a box or perhaps lie on her/his back. The primary concern is to move to a position where the dreamer feels comfortable in dealing with the dream image.

Once the dreamer has made contact with her/his central

dream figure s/he must deal with the image in a positive manner. If the hostile dream situation is too powerful to conquer, the dreamer must seek help in the form of allies, weapons, tools, or trickery to allow successful combat. When the dreamer has brought about a more constructive course of action in her/his dream, s/he asks the main figure to take her/him to the source of it/s power. At this point of the dialog, the client may make any number of requests upon the figure.

Stage 3: Resolution. In the style of the Senoi Indians, the dreamwork draws to a close with the dreamer's asking the primary figure for a gift. The gift seals the alliance between the dreamer and her/his central dream image. The gift should represent the essence of the power of the dream spirit. No specifications are placed upon what the gift shall be except that it have some personal or universal meaning or utility. When the dreamer has received her/his gift, s/he is asked to make a physical sketch of her/his gift or to write down her/his poem, song, or solution. From the preliminary recordings of the gift, the client may select those gifts which are particularly meaningful to her/him in order to make more permanent representations such as a painting, a wood carving, a sculpture, or a tapestry.

If the dialog and confrontation with the primary figure have been successfully resolved, the image will generally give an appropriate gift freely and readily.

Since much of the dreamwork is done at a metaphorical or

symbolic level of meaning, it is not unusual for a client to be unable to attach significance to his gift immediately. However, s/he is advised to save her/his gift and see if through experience or through deeper self-understanding the gift reappears and its purpose is made clear.

Garfield (1974) provides six steps and a check list for use in applying the Senoi System of dream control:

1) Determine that you will shape your dreams in accordance with the Senoi rules, begining with confrontation of danger in your dreams.

2) Each morning review your dreams of the night before, using the Guide for Applying the Senoi System (below). See how far you are able to progress in "yes" responses to the guide.

3) Note what mistakes and successes occurred in your dreams, and what are your plans for future dreams? Congratulate yourself on your successes.

4) Preserve an expression of all beautiful or useful gifts and treasures obtained in your dreams. Paint them, write them, sing them, dance them, or give them appropriate form in waking life.

5) Share your dreams and your progress in the Senoi system.

6) Don't get discouraged as mistakes occur. Successes will be even greater with persistent effort (Garfield, 1974).

Check List For Applying Senoi System of Dream Control

1. Did you have an enemy in this dream? Y_ N_

2. What type of enemy was it? a) Aggressive image__
   b) Uncooperative image__
   c) Amorphous threat__

3. Label the enemy. _____

4. Identify the category of aggression. _____

5. Did you advance toward the enemy? Y_ N_

6. Did you attack the enemy? Y_ N_

7. Did you ask for help in attacking, if necessary? Y_ N_

8. Did you receive help if asked for? Y_ N_

9. If you were injured or killed, were you reborn? Y_ N_

10.Did you injure your enemy? Y_ N_

11.Did you successfully fight off your enemy? Y_ N_

12.Did you kill your enemy? Y_ N_

13.Did you ask your enemy for a gift? Y_ N_ (Garfield, 1974, p. 115).

Carriere & Hart (1977); Faraday (1974); Garfield (1974); Herod & Smith (1982); Murray & Murray (1978) and Williams (1980) have all used the Senoi method and report sucessful elimination and control of the nightmare.

It should be noted that the Senoi method of dream control involves more than the three principles mentioned above. The full range of Senoi rules can be accessed through Stewart's article in Charles Tart's (1969) book Altered States of Consciousness or in Garfield (1974).

Group Methods

This section will be devoted to descriptions of small group approaches to working with the nightmare. It should be noted that there is no reported literature focusing on and describing methods of group work with traumatic nightmares. Therefore, the techniques presented here are adapted from reported group dream work.

Some Issues on Group Dreamwork

There are a number of issues that need to be clarified before work on traumatic nightmares within a group setting is undertaken. Ullman & Zimmerman (1979) and Williams (1980) state that these issues include the following:

Composition of the group: Who will be in the group? Will the group be heterogenous or homogenous (for example, will members include survivors of a specific trauma (only rape victims) or will the group include general trauma survivors (victims of crime)?

Purpose of the group: Why are the members meeting together? A statement of purpose can be prepared and may be read at the first meeting or a statement of purpose can be prepared with the members cooperation in the first meeting.

Group size: How many members will be invited to join? Williams (1980) advises that any dream group with more than four participants limits the full processing of a dream by each member. Whether each member will share a nightmare each session or only one or two members per session, will help determine the group size.

Time arrangements: When, where and for how long will the group meet? For example, the group could meet once a week for 2 hours and meet for six weeks with the option of renewing the group after the six weeks.

Group contract and ground rules: The ground rules may include safety and control rules such as the dreamer having the right to privacy and to stop the process when s/he

chooses. Other rules like journal keeping and the responsiblities of the members and leader should be outlined.

A contract can be drawn up which each member signs. The contract can include a list of rules and statement of purpose. For example, the undersigned agree that: (a) We are here to focus and work on our nightmares; (b) we will attend all sessions unless absolutely impossible; (c) sessions are closed to visitors; and (d) dream content and work is confidential. The contract can also be done less formally, depending on the group and the leader.

Group structure: The basic structure Williams (1980) has found most effective is to begin with meditation, do some simple ritual like lighting a candle, and then have people share the dreamwork they have done between dream group sessions. Next, each person shares a new dream and receives task suggestions from the leader, and sometimes from group members, for re-experiencing the dream during the week. Some dreamwork process may also be initiated during the dream-sharing time. Dream session is brought to a close meditatively with silence, a circle of hands, and the blowing out of the candle. The leader needs to be sensitive to the structure and its transitions so that the structure itself will be a containing base for members' work.

The leader's qualities and role: the role of the leader is to insure that the process evolves as it should and that the needs and rights of the dreamer and group members are respected. The leader need not be an expert on dreams and

nightmares, however, s/he needs to have an awareness of the specific techniques and of how they work.

Williams (1980) makes the following recommendations for the group leader:

> -Become increasingly aware of your own assumptions and your tendencies to guide the process your way rather than the way the process itself seems to want to go.
>
> -To avoid power struggles between yourself and others, continually check as to the effects you and the process are having on group members.
>
> -When a conflict develops between you and a dream sharer, almost always let the sharer have the ascendency.
>
> -You are responsible for part of the process, as are those in the group. Differentiate continually who is responsible for what.
>
> -When you get into difficulty, maintain consciouness, let go of everything, and let a healing source emerge.
>
> -Be aware of yourself all the time, but be focused also on the larger process of which you are only a small part.
>
> -Let your own dreamwork help you make conscious how you are carrying the leadership role.
>
> -Be willing to be alone and different from the group.
>
> -When you are not in the leadership role, drop it completely. Play with it as you use it and you will be much less subject to identification and inflation.
>
> -Live yourself what you teach. We lead others because we are ourselves in need. Leading others can evoke our own growth if we honestly take back what we give away. Be willing to be continually guided by those you teach and by other sources,inner and outer.
>
> -The deepest process happens when one becomes a channel for what is really at the core of a

> nightmare.To do this, practice clearing yourself of outside concerns before group session begins. After dream sessions, clear yourself by meditating on the process and your part in it. Basically, prepare before and process after. Acknowledge what has happened to you and the group (Williams, 1980, p. 247).

Other issues may surface and before starting a group, the counsellor should be aware of group dynamics and group processes. For more information on group counselling, see VanderKolk (1985).

Senoi Method

Johnsgard (1969) describes his way of using Senoi principles in a group situation. The group members are instructed to get comfortable, relax, close their eyes, and remain silent until the client has finished, opened her/his eyes, and discussed her/his associations with the counsellor, at which time they are invited to break their silence and enter the discussion.

When the client is relaxed s/he is asked to attempt to bring the dream into the present and to re-experience it. S/he is asked to make the dream a "here and now" experience, and is instructed to begin by attempting to visualize and carefully describe the situation (objects, scene, people, action, feelings) in the earliest stages of the dream which s/he recalls. The client is asked to describe all feelings s/he experiences, to expect the therapist to ask questions and make suggestions, and always to speak in the present tense.

In the re-creation of the dream the client is encouraged to stand her/his ground and confront the image in a progressively positive fashion. The client may be asked to stand still, carefully describe the image, approach it or whatever seems appropriate. When the client is too frightened to move from one step to another it is helpful to take a bit of time and ask for a careful description of the image and its behavior as well as carefully inquiring about the client's feelings. If the client is unable to proceed we will move on past a troublesome part of a dream to some other aspects of importance and return to the avoided confrontation at a later time or session.

In the case of some very threatening images and situations it is wise to allow the client to move completely at her/his own pace and choose her/his own direction with little or no pressure. In some cases the circumstance elicits such intense fear that it is necessary to suggest a change that will give the client more control of the situation. For example, changing a detail of image or scene, even a small detail such as the color of the sky.

Wallis (1980) also uses the Senoi principles in group work. The group leader asks the client to go back into the dream and relate what can be seen, and what is happening in the present tense. There are six main stages of the dream: the key, the embellishment, the main figure, the gift, the artifact and the quest.

The Key -This is the basic point from which to develop

the re-experience of the nightmare and is an index point from which total dream recall may begin. To re-establish active communication with the dream universe the dreamer returns to the last (or most important feeling) dream Key that s/he remembers. Another way of finding the Key is to ask the dreamer what feeling was experienced when they awoke. This feeling is the Key.

The Embellishment - Once the dreamer is in the dream recall, it is essential that active re-experiencing the events using the present tense is undertaken. It is important to remain as concrete and tangible as possible. Embellishment is important because the description and the filling of the dream setting enables the dreamer to get deeper into the experience. Counsellors may encourage the dreamer by using positive double binds, e.g. "Take all the time you need to get in touch with your nightmare and let me know when you are there. Remember you are the master of your dream universe." The Embellishment phase is concluded when a Main Figure emerges.

The Main Figure - Thee aim is to identify and isolate a Main Figure so that conversation may occur between it and the dreamer. Usually the Main Figure presents itself readily. If the figure is unclear the dreamer may move closer to it or further away from it, whatever feels comfortable to the dreamer so that s/he might see and speak with the figure successfully. The counsellor uses paradoxic suggestions, e.g. "Take all the time you need to approach the figure and let me

know when this is done". By accepting the direction, the dreamer acknowledges that the task will be difficult but s/he will be successful. The object is to approach the Main Figure and to seek its source of power so that the energy may be taken back and used for the growth of self.

The Gift - The receiving of a gift from the figure of the nightmare is the proof that the self and the power centre of the nightmare have communicated and accepted each other. A gift should represent the "essence of a spirit's power". Check after the Gift has been obtained that it does in fact represent the power of the spirit or figure. Once the Gift is obtained then the energy of the dream has been accepted by the dreamer and the message of the dream is answered either consciously or in the subconscious.

The Artifact -This and the final stage of dreamwork is completed in the awake state. To span the gap between the dream and the awake worlds, the dreamer is asked to sketch the Gift and retain the drawing in a prominent place.

The Quest - The aim of the quest is the attainment of the gift from the immediate environment. If the gift is not readily available then the individual searches for it. Again, reinforcement and time structuring toward finishing off the nightmare and full integration of the nightmare message is the object of the questing process.

Wallis (1980) has noticed that dreams may be finished in a therapy session and the client will have the finished/changed dream that night. Also, it seems that as a

person develops greater self esteem, deeper and often more traumatic memories will come from the subconscious, at a time when the client has more resources to deal with the repressed facts.

Guided Re-entry In The Group

The guided re-entry method, described in the individual counselling section, can also be used in the group setting and Williams (1980) describes how this is done. He stated that in a dream group setting everyone is asked to close their eyes and get into a meditative mood of alert emptiness. Each person, by letting go to their own images, will have an individual experience of the dream. Thus one person's dream effectively becomes every person's dream. The dreamwork guide then asks questions and gives suggestions to the dream sharer. The sequence of questions could go something like this:

A) At what point would you like to re-enter your dream?

B) Would you describe to us the scene in detail?

C) Now would you let the scene materialize just as you dreamed it but also letting go, without censoring, to new things developing. Also, you are free to make whatever choices you wish to make.

D) Why did you make that choice? What if you did the opposite or another choice?

E) If you feel inadequate or too afraid you may bring in a helper or a healing symbol. Who would you like to bring into you dream now? Do it and see what happens.

F) Why don't you let the dream complete itself? What would you like to do about the blocks?

G) Does it feel now like things have come to resolution or found a resting place? If so, then what gesture or action would you like to do with your dream beings before you see the scene for the last time for a while, and knowing that it will always be there as a resource to re-visit when you choose? Good, do it and slowly come back to this reality and open your eyes and look around (Williams, 1980, p. 186).

After such an experience, which can take from twenty minutes to two hours, people are in a deeply introverted and numinous state. All sense of linear time has vanished and the dream has become every person's dream who hears it. The dream guide then calls for any who would like to share to give their own experience of the dream re-entry, but without analyzing it or interpreting what the dreamer's experience was.

Suggesting Dream Tasks

This method involves giving people tasks to do with their nightmares. According to Williams (1980) suggesting tasks can be incorporated into seven steps:

1. Hear the dream while it is being said at a deep a level as possible. You might even close your eyes.

2. Obtain any immediate feelings or comments from the dream sharer. Do not go into these much or you will be drawn away from the dream itself.

3. Objectify the dream. What is the person doing or not doing in the dream? What are the major issues, conflicts and unresolved situations in the dream? What are the healing factors in the dream?

4. Next, focus on one aspect of the dream and develop it further. Of these issues and images, what seems most key or central? What do you now most want to work with?

5. Out of what has happened, suggest tasks to do during the week. Translate the methods into the specifics

of the nightmare itself. Often, tasks will be combinations or variations of methods, or they may not be directly contained in any of the methods as such. Sometimes ask if anyone else would like to also suggest a task.

6. Check things out by having the sharer restate the main tasks and what s/he has gained about the dream so far. This is essential to make sure the leader and the sharer are in tune.

7. Allow a moment of silence to assimilate energies before going on to the next person (Williams, 1980, p. 248-249)

In choosing tasks or techniques for working on the nightmare, Williams suggested that the counsellor:

-Let things come to you no matter how wild they seem. Then choose whether they are appropriate and consistant with the nightmare.

-Develop a varied and large repertoire of dreamwork methods and tasks. Go beyond what works well for you to what is exciting for others as well.

-Make tasks specific in terms of the nightmare itself and in terms of the methods to be used. Give the task as a question but add to it the method for actualizing it, and sometimes the goal of the process.

-Almost always get feedback on each task suggested. Does the task tune in or create resistance or both?

-When you commit yourself to a process technique in a dream session move ahead and go into it immediately. To retreat creates hesitation and insecurity.

-Generally, do not answer your own questions. You may rephrase your questions to obtain variety and clarity.

-At the end of an interaction, sometimes refocus with a question such as "Out of all this, what is the major energy in the nightmare for you right now?

-When a person reads a recorded dream quickly, have them slow down and really read it with feeling.

-One central goal of task suggesting is to get to the core of the nightmare. The leader suggests tasks inspired by her/his intuitions, but also tries to design

tasks by which the person is moved.

-Dream tasks may be suggested by other members of the group, usually in the form of questions. Train participants not to give interpretations or lengthy comments, but to translate these into questions which leave the possibilities for meaning open. Task suggestions can also be written on slips of paper and given to the sharer.

-Usually have the person write down your task suggestions in the journal while you are giving them. They may be otherwise easily forgotten in the heat of he process.

-When as a leader you are at a loss as to what to do next ask the the dreamer for response. "What would you like to do now? What is going on with you right now? I'm at a loss. How about you?"

-In doing tasks, give some indication of the amount of time you would like to take. You need to be careful also not to arbitrarily cut things off. Seek a natural point of resolution and transition as the place to stop.

-Do not comment too frequently on people's responses. An appropriate comment is usually brief, gives the essence and shows caring.

-When there is little time, ground what you are doing in some everyday specific thing that the person can work on.

-Be aware as to whether a person is really responding to your questions or not. Check it out.

-Be aware of your issues as leader versus the issues for the nightmare sharer. Own your own issues and recognize the other person's issues.

-Tension developed by contrasting both sides of an issue may be creatively left until resolution occurs naturally, or it may be resolved through choice, either by saying no to one thing and yes to another, or by choosing a third point which unifies the opposites.

-When a person is hesitant to share, accept their hesitation but coax them a little further by asking them why, or how they are feeling, or by pointing out alternatives and the values for sharing. Maintain the relationship with warmth, humor and insight. Do not baby people. If they did not want to grow, they would not be there.

> -Focus on processing the nightmare more than on processing a person's reactions to the dream. Always focus and refocus on the dream itself (Williams, 1980, p. 249-251).

The first part of the dream session is devoted to sharing dream task experiences done during the week. Each person may share. A participant may remind listeners of the essentials of their nightmare and give the hightlights of the dreamwork experience. Then, according to Williams (1980) the leader can then choose any of the following:

> a) No verbal comment. The work and the presentation stands on its own.
>
> b) A brief feeling supportive comment which is nonevaluative. "It looks like a lot happened for you. I'm sure we've all been through that one ourselves," for example. Not "You did wonderful dreamwork".
>
> c) A brief comment which gives the essence of what the person went through.
>
> d) Key questions which emphasize the value of the experience. "What is the essense for you here? What might be the next step you could take? How does your dreamwork relate to your original dream? What might you do further"
>
> e) Suggest further tasks coming out of the dreamwork. (Williams, 1980, p. 251-252)

Further, Williams (1980) advised that the leader should:

> -not take the other person's experience away from them. Not "How wonderful!" but "How do you feel about what has happened for you?" Then after the person's response you may choose to give some of your own feelings, but also owning them. "That is exciting dreamwork to me. I'm sure we all can learn from it."
>
> -If someone has not done dreamwork, they can usually be encourged to share a comment about the dream (Williams, 1980, p. 252)

Then the leader suggests at least four and possibly up

to eight different tasks. The dream sharer writes down the tasks as they are give. The emphasis is on choice. Do not necessarily do all the tasks but do the one which you have the most energy for. At the end the leader may ask about the person's response. Do some of these task suggestions feel right to you?

A variation on the above involves the leader suggesting that they do a dreamwork task together right there in the group. This may take the form of a guided re-entry into the nightmare or acting out briefly some action in the nightmare. Direct process is chosen when the person is felt to need support or initiation into the technique.

Other paticipants in the group, usually after the dreamwork leader is finished, may give a task suggestion or two. But this is limited so as not to confuse the person with too many different tasks, some of them possibly contradictory. At the end when the tasks are written down and after a little silence the next person begins to share.

The leader is not the evaluator of the tasks. The leader may appreciate, give support, clarify, add information and even suggest new tasks. The focus is self-direction in doing dreamwork. The leader avoids being the authority in the situation and is the facilitator for the process, not the recipient of the process (Williams, 1980).

Dream Tasks

The Rehearsal and Key Questions methods (and all other

techniques described for use in the individual counselling section) can also be used in group settings or used as dream tasks for homework. Thus, clients can be assigned Senoi, self-re-entry, continuing the dream, and story line alteration techniques as ways of working on their nightmare in the group or at home to report back to the group (see Appendix B for a synopsis of these tasks). Counsellors should also familarize themselves with other dreamwork techniques not mentioned here in the event that these techniques may be useful for the nightmare sufferer at some point.

Summary and Conclusion

A review of the literature on the direct psychological treatment of traumatic nightmares has been presented in this chapter. The overview of the research included behavioral methods (such as desensitization, implosive, therapy and flooding), cognitive interventions, relaxation techniques, story line alterations, and "face and conquer" methods. All of these approaches to working with nightmares were found to be helpful for some individuals thus giving evidence for the therapeutic value of working with traumatic nightmares. However, it was noted that there are few research studies on the treatment of traumatic nightmares and most of the research to date has focused on treatment of ordinary recurring nightmares. As well, much of the reported research consists of individual case studies and may not be generalizable to a larger population of traumatic nightmare

sufferers. This evidence suggests, then, that further research is needed on the success of the direct treatment of traumatic nightmares.

This chapter also provided step-by-step instructions for working with nightmares within an individual and a group setting. Direct psychological methods outlined included individual counselling approaches such as: Rehearsal, Key Questions, Re-living/Amplification, Guided Re-entry, and the Senoi Method. Group methods described were: the Senoi, Guided Re-entry, and Suggesting Dream Tasks. It was hoped that the Step-By-Step outline of these methods would enable counsellors to incorporate dream work into therapy with trauma survivors.

Wilmer (1986) stresses that inexperienced people who are not trained in dream analysis should not dive into these troubled, dangerous waters, but should know that listening itself, without any interpretation, allows the dreamer to retell her/his story, and in the process, possibly change her/his attitude and dreams. However, this writer believes (as do others such as Faraday, 1974; Garfield, 1974; Mallon, 1987; Morris, 1985; Toombs & Toombs, 1985; Shohet, 1985; Ullman & Zimmerman, 1979 and Williams, 1980) that counsellors need not be "experts" in dream analysis to do work with dreams and nightmares because the dreamer has personal authority over the dream. Also, The aim is not "dream interpretation" but "dream appreciation" (Toombs & Toombs, 1985). Thus, the role of the counsellor is not to tell the

client what the dream means, but to help the client to learn from her/his own nightmare. The dreamer is in control of the process and is the expert on the dream. However, some awareness of dream work methods and a belief in the value of dreamwork is essential. It is also essential that counsellors have an attitude of respect for the dreamer and the dream as well as an understanding and patience for the trauma and the healing process.

The attitude of professional helpers toward traumatic nightmares can help the clients to accept and to integrate the unconscious experience. The reluctance or resistance of counsellors to work with or just patiently listen to the nightmares of trauma survivors reinforces the sense of rejection that characterized victims and may doom them to live alone with the terrors of their nightmares.

The ultimate effectiveness of dream work is contingent on appropriate use of counsellor techniques such as pharaphrasing, reflection, clarification, open-ended questions, summarizing and proper use of silences. The traditional core conditions of any therapeutic relationship, namely, accurate empathy, non-possessive warmth, and genuineness are crucial to the therapeutic process.

The next time a client has a nightmare or bad dream, think of it as a gift rather than a curse, a challenge rather than a threat. For in the nightmare is the opportunity to acquire greater confidence, self-fulfillment and wisdom.

CHAPTER 4

SUMMARY, DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

While many authors reporting the human reaction to trauma and Post-Traumatic Stress Disorder note that nightmares are central symptoms of the response to trauma, few suggest or explain how to work with the nightmare as part of the treatment process. This paper has attempted to fill this void by providing detailed descriptions of a few methods of working with post-traumatic nightmares. Further, this study has examined the nature of trauma, post-traumatic stress disorder and the role of traumatic nightmares in the reaction to and recovery from traumatic experiences. It was proposed that individuals could work with the trauma in the dream state, thereby assisting in the adaptation and integration of the trauma in the waking state.

The following questions were investigated:

1. What is the human reaction to trauma? Are there universal reactions? Are there similarties in responses between different trauma survivors? Are there orderly stages of "recovery"? What is successful adjustment?
2. What is the post-traumatic nightmare? How is it different from other nightmares? Why and how is the post-traumatic nightmare important in the healing process? How can one work with the traumatic nightmare in a counselling setting?

Summary of Chapter 1: The Post-Traumatic Experience

This chapter explored the human reaction to trauma. The material presented indicates that the traumatic response can take many forms depending on a number of interacting variables. One can expect that regardless of the trauma experienced, the survivor will respond in a manner that incorporates any of a number of reactions. Each victim responds in their own unique way, however there are clusters of symptoms that are common to trauma survivors' experiences. These common symptoms are labelled by the American Psychological Association as Post-Traumatic Stress Disorder and is reframed as Post-Traumatic Stress Reaction by this author.

This chapter also explored a number of stage models designed to represent the human reactions to trauma. It was noted that empirical evidence to support the existence of stage models is lacking (Silver & Wortman, 1980), yet an awareness of the possible stages is helpful in alerting us to the patterns that may occur thus providing an outline within which to place the individual's unique experience. Rather than stages, it is suggested that acute and long-term as well as cycles or alternating phase provide a better description of the post-trauma experience.

It was also noted in this chapter that integration of the traumatic experience involves re-experiencing the trauma through intrusive thoughts and images. Therefore, the central purpose to be achieved in the treatment of stress

response is to facilitate the fullest possible re-experiencing and recollecting of the trauma in the here and now. Helping the client to fully experience both the negative and the positive aspects of the trauma experience is critical to a full integration of the trauma. The focus of counselling, then, should be to provide information regarding the post-trauma reaction, support and empathy to the survivor. The survivor deserves to be understood, assured, respected and informed that their reactions are normal and that the intensity will diminish with time.

Summary of Chapter 2: Post-Traumatic Nightmares

This chapter focused on nightmares. When ordinary nightmares, night terrors and traumatic nightmares were compared, it was noted that post-traumatic nightmares are a distinct phenomenon that can be distinguished from both night terrors and ordinary nightmares in a number of ways. While they resemble dreams containing imagery, speech, thought and emotion, they differ because they are accurate repetitions of the preceding traumatic experience. The content is repetitive, more like a memory than a dream or fantasy, a memory that is played over and over and easily recalled upon awakening. Typically traumatic nightmares can occur in several stages of sleep and in fact can occur in any stage of sleep. They are commonly experienced by children and adults, after any life-threatening trauma. Thus, traumatic nightmares were found to differ from nightmares and night

terrors in content, amount of recall, stage of sleep they occur in and age of the individuals who experience them.

The re-experiencing phenomena that occurs for survivors after a traumatic event was also examined in this chapter. It was found that some explain re-living the trauma as an attempt to come to terms with the trauma (Greenberg & van der Kolk, 1987), a method of integration or new information storage (Rycroft, 1979), a wish to desensitize the experience (Dreistadt, 1972), a wish to be reassured of survival (Renik, 1981), cognitive information processing involving a completion tendency (Horowitz, 1976) or a repetition compulsion (Freud, 1965).

In this chapter, it was also noted that the re-experiencing function of traumatic nightmares is thought to serve as an adaptation to the trauma. The theories of the adaptation to stress function of nightmares fall into two categories, the mastery theory and the compensatory theory. The mastery theory suggests that the dream allows the dreamer to master the trauma by rehearsing the stressful event. The compensatory theory indicates that the dream aids in adaptation to stress by incorporating content that is opposite to the actual stressful event thus creating psychologicial homeostasis for the dreamer.

As well, a new theory of the adaptation function of dreams was discussed. This theory by Wright (1988) and Wright & Koulack (1987), states that dreams may oscillate between mastery and compensatory functions in order to allow

adaptation to the trauma. It was noted that the mastery-compensatory theory is most consistent with evidence presented on the post-trauma reaction in chapter 1, and it seems logical that the dreaming reaction to trauma would be similar to the waking reaction to trauma because dreams are a continuation of the waking experience (Kramer, 1988).

This chapter has determined that traumatic nightmares serve an adaptive function to stress or trauma and that the nightmare is a natural part of the integration and healing process. It follows, then, that there may be therapeutic value in working with traumatic nightmares just as there is value for the survivor in working with waking thoughts and memories of the trauma. Working on and facing the nightmare may increase a sense of active mastery and decrease avoidant behavior.

Summary of Chapter 3: Working with Post-Traumatic Nightmares In Counselling

This chapter presented a review of the literature on the direct psychological treatment of traumatic nightmares. The overview of the research included behavioral methods, cognitive interventions, relaxation techniques, story line alterations, and "face and conquer" methods. All of these approaches to working with nightmares were found to be helpful for some individuals thus giving evidence for the therapeutic value of working with traumatic nightmares.

This chapter also provided step-by-step instructions for

working with nightmares within an individual and a group setting. Direct psychological methods outlined included individual counselling approaches such as: Rehearsal, Key Questions, Re-living/Amplification, Guided Re-entry, and the Senoi Method. Group methods described were: the Senoi, Guided Re-entry, and Suggesting Dream Tasks. This manual for working with nightmares was provided with the hope that counsellors would be able to easily incorporate dream work into their therapy sessions with survivors. The assumption is that counsellors need not be "experts" in dream analysis to work with nightmares, but some awareness of dream work methods and a belief in the value of dream work is essential.

Discussion, Recommendations and Conclusion

Personal and professional experience with trauma and survivors began to raise questions about the therapeutic value of working with post-traumatic nightmares. This study proceeded from the hypothesis that post-traumatic nightmares are valuable in the healing process and that working with them would facilitate healing.

Various researchers have reported on the common occurance of post-traumatic nightmares after any traumatic event. Some authors even state that they work with the nightmare in therapy with survivors. However, few authors describe exactly what method to use and how to work with the traumatic nightmare. The aim of the present study was to present a manual of dreamwork that would describe in detail,

various methods of working with the post-traumatic nightmare.

The author examined the human reactions to traumas, post-traumatic nightmares and methods of working with nightmares and concludes that: (a) Nightmares fulfill an adaptive function to traumatic situations; (b) The post-traumatic nightmare is therapeutically valuable in the healing process for trauma surviors and nightmare work can be used as a tool to aid in this process; (c) Post-traumatic nightmares can be worked with in the counselling environment and counsellors can learn to help trauma survivors with their reactions to trauma and with their nightmare experiences; and, (d) there are methods of dreamwork that can easily be incorporated by counsellors into their existing repertoire of counselling skills.

A trauma is a condition resulting from a startling or shocking experience that has a lasting effect on mental life. As this paper has indicated, it is crucial that the survivor be encouraged to share the details of the trauma. Sharing these horrifying emotions and experiences can be expecially frightening and difficult for the client and counsellor. Once the counsellor admits the knowledge of the survivor's experience into her/his awareness, s/he is changed in fundamental ways and s/he may even find that s/he also has nightmares related to the survivor's experience (Shatan, 1973 and Garfield, 1987). The trauma experience, then, has lasting effects on the survivor as well as those with whom s/he chooses to share the trauma experience.

Further, the assessment and treatment of Post-Traumatic Stress Reaction involves a challenging set of factors, including the apparent need for special professional and personal qualities on the part of the counsellor (Scurfield, 1985). These include the willingness and sensitivity to probe quite directly into various aspects of trauma experiences and the ability to face honestly one's own reactions and those of the survivor to such probes. The counsellor must have the sensitivity to navigate the obscure boundaries between uncovering that which the survivor has been trying to avoid (recognizing that a certain amount of denial is healthy but to totally deny impedes the healing) and the full integration of the trauma experience. The most important event that activates and facilitates this integration is empathetic validation from another person who is willing to be moved by the client's pain.

The first recommendation of this thesis, then, is that counsellors be willing to share the pain of the survivor's trauma experience. Counsellors should share this pain without minimizing or pathologizing the trauma or the survivor's reaction to it and should recognize that post-trauma reactions can take on a variety of forms and symptoms. As well, the post-trauma reaction may last over a period of years, and the client may find it necessary to tell and retell her/his experience many times and in many ways before s/he feels "talked out". Thus, these extraordinary traumatic events and reactions to them require extraordinary efforts,

both by the client and the counsellor.

The second recommendation has to do with post-trauma research and the re-experiencing phenomenon. Re-experiencing the traumatic event in the form of intrusive thoughts and images is a very common reaction to trauma. Yet the role of visual imagery in the post-trauma reaction has not been fully appreciated.

In the research literature on trauma, as in the theorectical work in this area, there has been a neglect of imagery and there have been few attempts to systematically collect information about imagery. Post-trauma reaction research has primarily focused on measuring symptoms such as anxiety or depression and broad indicators of life adjustment in educational, vocational, and social areas. The frequency and types of intrusive imagery are not reported even when PTSD is used as a conceptual framework (Notman & Nadelson, 1976). Brett & Ostroff (1985) also point out the tendency to minimize the role of imagery in clincial theories of PTSD, research investigations of PTSD and in the diagnosis and treatment of trauma survivors.

This lack of attention to intrusive imagery in the literature and the fact that it is commonly experienced by trauma survivors, suggests that much more research into the re-experiencing phenomenia and intrusive imagery, is necessary. For example, we need to know if the function of re-experiencing the trauma is (a) an attempt to come to terms with the trauma; (b) a method of integrating or new

information storage; (c) a wish to desensitize the experience; (d) a wish to be reassured of survival; (e) is it cognitive information processing involving a completion tendency or all of the above. This knowledge should enable counsellors to better assess and counsel trauma survivors.

In addition, to further determine the function of nightmares in the post-trauma healing process, long-term research is needed. The literature to date suggests that the re-experiencing phenomena in the form of nightmares is thought to serve an adaptation function to trauma. Exactly how this adaptive function(s) works, though, is yet to be fully understood. Long-term research should try to determine if the adaptive function of nightmares changes over time (ie: mastery-compensatory theory) and if treatment needs to be designed to accomodate the particular function of the nightmare at the specific time in the healing process.

Post-trauma research should also examine the immediate reaction to trauma in dreaming and waking life as well as the process that healing takes. Both dreaming and waking life post-trauma experiences should be considered because of the similarities between nightmares and flashbacks (one occurs in the dream state and one in the waking state) and because there is a continuation between waking and dreaming life.

Halliday (1987) reported that there is therapeutic value in working with traumatic nightmares. His overview of the research found that behavioral therapies, cognitive interventions, relaxation techniques, story line alteration

and "face and conquer" methods have all been found to be helpful in treatment for nightmares. There are, however, very few reported research studies of the direct treatment of traumatic nightmares. Much of the reported research consists of individual case studies and few controlled studies have been attempted. Therefore, it is recommended that further research be undertaken on the effectiveness of direct psychological treatment of traumatic nightmares. Special attention could be paid to the use of dreamwork methods described in this paper.

The attitude of professional helpers toward traumatic nightmares and trauma reactions can help the client to accept and to integrate the trauma experience. The nightmare can be used to help the client attain greater confidence and control which was taken away from her/him by the trauma. It is important to reframe nightmares as something helpful and emphasize that something good (growth and learning) can come out of something bad (trauma).

> the only way through pain...is to go through it, to absorb, probe, understand exactly what it is and what it means. To close the door on pain is to miss the chance for growth...Nothing that happens to us, even the most terrible shock is unuseable (Sarton, 1980, p. 15)

Counsellors, then, should be open to the dreamwork possibilities and be willing to explore all areas of the trauma and the survivors reactions to it.

Fundamental to dream work and counselling is the bringing of resolution to conflicts and issues raised in the

dream and waking states. Dreaming or thinking about something does not usually bring resolution in itself. We must evoke resolution. This is the art of healing (Williams, 1980).

Garfield (1987) says that treating survivors for their nightmares is not a "fun" undertaking. But therapists who find themselves able to cope with the pain, even periodically, discover it is deeply worthwhile. The importance of this work is carefully expressed in her own words:

> ...as in the myths of old, those who endure great peril may, in the end, bring back from their treacherous voyage a treasure to share with humankind. Brave the waves with these [survivors], for if you and I will not, they travel alone (Garfield, 1987, p. 97).

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Appendix A

Methods of Direct Treatment of Nightmares

METHODS OF DIRECT TREATMENT OF NIGHTMARES

WAKING STATE:

Desensitization - A state of relaxation is repeatedly paired with brief presentations of anxiety provoking circumstances that are introduced in a gradual manner.

Flooding - Extinction of anxiety is achieved by continuously confronting the anxiety producing stimili.

Implosive Therapy - Extinction of anxiety is achived through imagining fear-producing situations and holding the anxiety at this pitch until anxiety extinguishes.

Rehearsal - The client is asked to re-tell the nightmare and the frightening events in detail recalling and re-living the emotions associated with the trauma and connecting them to times when similar emotions occurred.

Re-living or Amplification - Involves 4 steps: examining the images, clarification of affective and kinesthetic components, revivification, and integration. The client gives a detailed account of the nightmare, identifying feelings and sensations associated with the various images. The client re-experiences the nightmare while in a state of deep relaxation.

Story Line Alteration - Involves altering the anxiety provoking story line itself through rehearsal of different endings to the nightmare, confrontation of the nightmare figure or alteration of the dream detail in the waking state.

Key Questions - After sharing the nightmare details the client is asked questions about the nightmare in order helps clarify thoughts and emotions related to the nightmare.

WAKING OR DREAMING STATE:

Cognitive Interventions - Involves methods for reducing the perceived importance and realism of the nightmare. The client repeats to her/himself "It's only a dream" or "You have no power over me".

Suggesting Dream Tasks - Involves giving clients tasks to do with their nightmares.

DREAMING STATE:

Face and Conquer - Requires the dreamer to confront and/or alter the content in the dream while dreaming.

Guided Re-entry into the Dream State - The dreamer imerses her/himself back into the dream using re-visualizing of the dream and letting go to new imagery and dialogue. The intention of bringing resolution is also taken into the dream. The dream events are described to a guide

who is also in a meditative state and who asks questions and makes suggestions for activity during the process.

Senoi Method - Dream control method that involves changing the content of the dream. Fears should be faced by the dreamer and unpleasant situations made pleasant. The dream should not end without the dreamer asking for and aquiring a gift from the enemy.

Appendix B

Dreamwork Tasks

DREAMWORK TASKS

Rehearsal - The client is asked to tell and retell the nightmare in a variety of ways, recalling and reliving the emotions associated with the trauma.

Key Questions - After the nightmare is recorded in detail, the counsellor asks specific questions about the nightmare.

Senoi - The dreamer is encouraged to stand her/his ground and confront the image in a progressive and positive fashion.

Self-re-entry - The tasks is to re-enter the dream in a meditative state using visualization, imagery and dialogue to bring about resolution. There is no guide. The results are written down afterwards.

Continuing the Dream - Re-enter the dream at the end and allow it to flow spontaneously until point of resolution is reached.

Dialogue - Dialogue with the main character or emotion from the nightmare until resolution occurs.

Story Line Alteration - Altering the anxiety provoking story line through rehearsal of different endings to the nightmare, confrontation of the nightmare figure, or alteration of the dream detail in the waking state.

Re-writing the Dream - Rewriting the dream making creative changes: resolve conflicts, make the dream ego more assertive, complete or change actions. Rewrite the dream as a story, folktale or parable.

Four Quadrants - involves dividing a paper into four quadrants. The nightmare is drawn in three acts. In the fourth quadrant, imagine and draw a resolution.