Dream-Based Interventions and Post-Traumatic Stress Disorder

A Literature Review

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Abstract

With the vast amount of conceptual frameworks and research on dreams, datum suggests that dream-based interventions can be effectively utilized in clinical mental health settings. Additionally, a paradoxical relationship exists between dreams and trauma, so dream-based interventions could be of value when implemented in post-traumatic stress disorder (PTSD) treatment protocol. Integration of current dream-based interventions in conjunction with Individual Psychology could produce a protocol to target re-experienced PTSD trauma-related dreams. Attending to trauma-related dreams from a cognitive, emotional, and social perspective could have an impact on the treatment of concurrent waking-life symptoms of PTSD.

*Keywords:* dreams, PTSD, Individual Psychology
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Dream-Based Interventions and Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a stress-related disorder that results from exposure to a traumatic event (American Psychiatric Association, 2013). The intrusive symptom of recurring trauma-related dreams has a significant negative impact on the functionality of an individual on an emotional, cognitive, and social level. Recurring dreams as a re-experiencing of the initial traumatic event can be a predictor of more severe symptoms of PTSD (Mellman, David, Bustamante, Torres, & Fins, 2001).

Research on treating the symptoms of trauma-related dreams is uncommon in the mental health field, and conducted studies have included small sample sizes and differing theoretical orientations. While most treatments such as the cognitive-behavioral therapy approach, reduce specific symptoms of PTSD, an effective approach to address a number of complex symptoms (i.e., emotional distress, negative thinking patterns, and isolation) of PTSD has not yet been developed (Hill & Knox, 2010). Complementary treatments are effective when used individually, but research suggests that when used together, effectiveness is not increased because the treatments address the same symptom, just in different theoretical fashions (Foa et al., 2005; Foa et al., 1999; Paunovic & Ost, 2001).

Conceptual frameworks regarding the use of dreams have been developed by the most prominent names in the field of psychotherapy, such as Freud, Jung, and Adler. Additionally, dream-based interventions are currently being used in a clinical setting to address the symptoms of various forms of psychopathology (Hill & Knox, 2010). It may be possible that by drawing on past conceptual frameworks and integrating them with effective and empirically-supported dream-based interventions utilizing the most current clinical datum, a clinical protocol that encompasses all symptoms of PTSD could be developed. By targeting specific symptoms of
trauma-related dreams with effective dream-based interventions and a theoretical perspective that addresses the emotional, cognitive, and social elements of mental health, other significant symptoms of PTSD, such as isolation, may be treated.

**Dream-Based Conceptual Frameworks**

Dreams are an essential part of the human experience and have fascinated people for centuries (Givrad, 2016). According to Dallett (1973), the practicality of using dreams in a psychotherapeutic setting has been highly debated for quite some time. In fact, the use of dreams as a therapeutic intervention has been met with skepticism and scrutiny. Dallett stated that Freud’s conception of dream theory is the most widely used theory of dream work, second only to scientific approaches (e.g., the study of neuroscience). Differing conceptual frameworks exist regarding dream work from some of the most well-known names in psychology. For example, mental health professionals are familiar with the work of Sigmund Freud, Carl Jung, and Alfred Adler; however, most favor Freud’s psychoanalytic conceptual framework (Dallett, 1973).

**Freudian Framework**

Sigmund Freud theorized that access to the unconscious tendencies of an individual would allow for insight and healing (Montenegro, 2015). The concept of the unconscious is of utmost importance in Freud’s model of dream work. The unconscious is an internal psychic structure that houses a reservoir for anything outside of the individual’s conscious awareness or ego (Weitz, 1976). The ego is caught in an inevitable conflict between the superego and the id. The superego functions as a mechanism of morality and civility while the id acts on primitive and many times, sexual impulses (D’Amato, 2010). According to Freud, dreams are an invaluable avenue for accessing the personal, unconscious mind, and a dream is a disguise for an unfulfilled, repressed wish derived from the id. Commonly, the repressed material would be a
result of a traumatic experience from early childhood (as cited in Lombardi & Elcock, 1997). Most emotional dream themes revolve around aggression, and most emotions experienced in a dream are of a negative connotation (D’Amato, 2010). In fact, it is uncommon for individuals to associate positive emotions with dreams (D’Amato, 2010). According to Freud, negative emotions are unacceptable in conventional society, are repressed, and burst into awareness in a passive sleeping state (as cited in Dallett, 1973). In the passive sleeping state, the individual’s ego is at its most vulnerable. Dallett suggested negative emotions or impulses are so unacceptable that they must be clothed in incomprehensible images. As a result, the ego is partially defended and kept in a healthy state while discharging the impulse from the personal unconscious of the individual.

Freud saw dreams as useful tools for resolving early traumatic experiences (Dallett, 1973). Freud’s patients would share a dream in the present tense and then participate in the act of free association. The initial dream content is the latent meaning of the dream. Many times the dream content is confusing and incomprehensible to the patient because it is in its disguised, acceptable form (Dallett, 1973). Everything the patient associates after sharing the dream, regardless of how many degrees of separation from the dream it may be, would ultimately tie back to the original dream experience. Freud claimed that through free association and interpretation, the manifest level of meaning of the dream would be unveiled. The manifest level of the dream is the interpreted material, and a message from the unconscious mind, that could be useful to the patient, therapist, and the therapeutic process (Grünbaum, 1994).

Lombardi and Elcock (1997) provided an example of Freudian dream interpretation. A young woman was having a conflict with her parents about the man she was dating. She was troubled by a dream and sought guidance from Freud. In the dream, the woman was in a place
that she found comfortable, but she did not recognize it. The furnishings were poor relative to her home in waking life. It was a hot day and the brother of the dreamer’s Italian boyfriend came to the house wearing a Mexican sombrero. The dreamer received a letter from the brother stating that the dreamer’s Italian boyfriend had married someone else. The dreamer woke in a distraught and emotionally-pained state. According to Lombardi and Elcock, Freud’s interpretation of the latent dream material would be that the young woman was having ambivalent feelings about her relationship with her Italian boyfriend. Her Protestant parents did not approve of the relationship to the Catholic Italian, and the woman internalized the disapproval. Unconsciously, the woman carried the same doubts and skepticism as her parents. The unrecognizable environment and the brother with the sombrero represented the dreamer’s unfamiliarity with the boyfriend, his culture, and the overall romantic relationship. The letter delivered by a brother representative of many differing cultures, represented the delivery of the dream message ultimately informing her that the relationship was terminated. This example illustrated how latent material disguised the dreamer’s repressed doubts and concerns about the stigmatized relationship (Lombardi & Elcock, 1997).

**Jungian Framework**

Carl Jung, like Freud, held that dreams functioned as messages from the unconscious mind of an individual; however, Jung’s theory of the unconscious was not as narrow as Freud’s conception (Dallett, 1973). Jung believed that in addition to an individual’s personal unconscious, consisting of memories, impulses, etc., a collective unconscious existed and was shared by all of humankind. Jung believed this deep well of human unconsciousness could be a great source of wisdom. Weitz (1976) posited that an individual lived half of life in a conscious state and the other half of life in an unconscious state. Therefore, it would be therapeutically
beneficial to give attention to the unconscious life of an individual through the most accessible means possible: dreams. In addition, Weitz believed that dreams could not merely be manifestations of repressed impulses because they are connected to the collective unconscious of the human race. According to Jung, von Franz, Henderson, Jacobi and Jaffe (1968), in addition to the influence of primitive impulses, archaic cultural constructs such as mythology, religion, and art influence the outward behavior and dreams of individuals. Jung suggested dreams were symbolic representations of an individual’s inner state and not a disguise for undesirable impulses.

Jung viewed the images and symbols within a dream as a language of nature incomprehensible to humans (Jung et al., 1968). Jung believed humans evolved into rational beings separated from this type of understanding. For instance, Jung viewed dreams as a product of nature, similar to the rings of a tree, which contain wisdom and information from the vast unconscious parts of the human mind (Jung et al., 1968). According to Jung (1916), dream images and symbols can be of a personal or collective nature. For example, familiar images or themes, like the house an individual grew up in, or an argument with a spouse, are derived from the personal unconscious. Images and themes of a more impersonal level, such as a castle or a climb up a mountain, can originate from the collective unconscious. These collective images or themes that are psychologically inherited are what Jung referred to as archetypes (Jung et al., 1968). Psychologically inherited images or themes that have reoccurred in stories and human experiences, are passed down from generation to generation, and are robust with meaning in Jung’s approach to dreams (Jung et al., 1968). By way of dreams, personal associations, and archetypes, the dreamer is able to follow the guidance from the Self (i.e., the center or nucleus of the psyche) to lead a more meaningful and purposeful life (Weitz, 1976).
Jung posited that the function of dreams was to contribute to conscious knowledge through psychological compensation (as cited in Domino, 1976). Jung suggested dreams portrayed the individual as they were and not who they perceived themselves to be. If an individual identified as passive and complacent in conscious life because of a past experience with abuse, then as a compensatory function, he or she may dream of an aggressive and assertive character to balance the conscious and unconscious experience. It is the therapist’s role to guide the patient to a subjective understanding of the dream through its symbolic images and thematic motifs, thus creating a therapeutically beneficial dialogue with the unconscious mind (Jung et al., 1968). In contrast, Freud’s process allowed the patient to use free association to eventually constellate the latent meaning with the manifest meaning. Jung’s approach would give particular focus to the dream content itself (Johnson, 1986). Jung believed every symbol served a purpose. Every association the individual has to that symbol would necessitate a relationship to the dream. Through examination of the individual’s associations and current state in conscious life, a meaningful message from the unconscious could be constructed to compensate for an unbalanced state of mind or view (Johnson, 1986).

**Narrative Therapy Framework**

Michael White and David Epston, founders of narrative therapy, encouraged clients to create new personal narratives, or stories, to reflect personal values (Findlay, 2016). The creation of a new narrative engages the client in a useful problem-solving approach. For instance, narrative therapists understand that an individual is not a passive observer in traumatic, anxiety-provoking, or tranquil experiences (Findlay, 2016). According to Findlay, in every experience, the client will do something to work through the situation. If an individual is struggling with a problem in life, they can weave negatively-viewed identity into that problem
and create a problem-saturated story. That is, it would be as if they were engaged in a parallel process of writing and living an autobiography. Identity and life experiences are affected by the perception of the personal narrative within an embedded problem (Beaudoin, 2005). When clients develop problem-saturated narratives, particularly narratives involving traumatic experiences, Beaudoin believed it was important to stress agency and strategy. Through conversation and a step-by-step reauthoring process, an individual can deem storied actions and narratives meaningless or unhelpful and recognize unnoticed actions and narratives that may replace a current problem-saturated narrative. That is, as an autonomous agent, the individual has the choice to alter the narrative with the ability to choose a new response strategy for seemingly overwhelming struggles (Beaudoin, 2005).

According to Montangero (2012), dreams are not stories, but are instead fragments of stories, or narratives, with no clear ending or logical sequence of unified events. Hence, narrative dream therapy may be an effective approach to address the confusing and emotional experience of dreams. The basic principles of narrative therapy can be applied to distressing or troublesome dreams through narrative dream analysis. Findlay (2016) suggested an active response to a dream is valuable in the understanding and transformation of the dream into a therapeutically beneficial experience. A client has a certain amount of autonomy or agency in how they react or respond in a dream. The process, according to Findlay, is that a client would be asked what he or she did to get through danger or resistance in the dream. The client’s responses may include creative defense mechanisms, safeguarding tendencies, or self-protecting efforts. The main protagonist of the dream, commonly the dreamer, teaches the dreamer by showcasing skills and knowledge necessary to manage the threatening situation (Findlay, 2016). Once a reaction has been identified, such as hiding or running, the action may be examined in
conjunction with the individual’s values and intentions. If the client’s reaction was incongruent with the values or intentions of the individual, then an alternative reaction (or plan) and narrative would be developed. Findlay suggested this approach was best-suited for recurring, threatening dreams such as those related to trauma. Dreams no longer happen to the client, the client establishes awareness and a sense of autonomy for use in the next dream occurrence (Findlay, 2016).

Findlay (2016) described an example of a man who dreamed he was being chased by another man. The dreamer believed that by running, he made the stranger larger and more threatening. After exploring the dream in therapy, the dreamer stated he would make a conscious effort to confront the frightening stranger (Findlay, 2016). By evaluating his reaction to the stranger, the dreamer acknowledged that running from the stranger was an ineffective reaction. He considered alternatives, explored his values, and utilized his agency in the situation. As a result, the dreamer would confront the distressing dream content instead of fleeing from it.

**Adlerian Framework**

Alfred Adler theorized that dreams were an expression of an individual’s subjective style of life, and not necessarily an interface between opposing worlds of the unconscious mind and the conscious ego of the individual. Instead, the dream is an attempt to arrive at a solution for a given problem (as cited in Ansbacher & Ansbacher, 1956). Lombardi and Elcock (1997) explained that dreams are a bridge between the problem and the individual’s lifestyle, regardless of whether that lifestyle is based on sensible or irrational principles. Unlike Freud and Jung’s approach, Adler proposed that the dream itself was not necessarily a message of wisdom (Lombardi & Elcock, 1997). Adler believed the dream was covered in the bias of an individual’s lifestyle and served the purpose of supporting the lifestyle, even if it was contradictory to
common sense and logic. The dream was useful in the future and guided the dreamer toward action during conflict, tension, or the achievement of a goal that was in harmony with the individual’s style of life (Ansbacher & Ansbacher, 1956). Adler was interested in the feelings associated with the dream. He believed that feelings were impartial and had validity whether in a waking or sleeping state (as cited in Lombardi & Elcock, 1997). If an individual experienced an intense fear or dread in a dream, it was valuable because somehow, it was associated to a conflict or goal the dreamer was attempting to resolve in waking life. For instance, the metaphoric nature of a dream is an attempt to avoid common sense and logic and is intended to deceive the individual into using private logic (Lombardi & Elcock, 1997). Lifestyle is filled with private logic, and the symbols in the dream are a product of private logic; therefore, every symbol has its own idiosyncratic meaning to the dreamer (Ansbacher & Ansbacher, 1956).

According to Adler, common archetypes do not exist (as Jung previously posited) instead, there is a direct relationship between the metaphoric images and symbols in the dream and the private logic associated with the dream (Lombardi & Elcock, 1997). Because of this association, every dream image or theme is a metaphor for inner and outer experiences.

In reference to Freud’s interpretation of the young woman’s dream, Adler would have a slightly different perspective (Lombardi & Elcock, 1997). The main focus of the dream would be its emotionality and how it was connected to her problem. The ability to please her parents was important to the young woman; however, her parents strongly opposed her feelings about the Italian boyfriend. The young woman knew that if her boyfriend ended the relationship or broke her heart, her parents would be right and she would feel the emotionality she experienced when she woke from her dream. Limited literature exists regarding Adler’s thoughts about
dream work and he did not publish an extensive theoretical and procedural framework for the interpretation or evaluation of dreams (Lombardi & Elcock, 1997).

**Individual Psychology**

Individual psychology was developed by Alfred Adler as a system of psychological concepts and principles that work as a theoretical guide through which psychotherapy can be facilitated (Ansbacher & Ansbacher, 1956). Adler was a physician that worked with Freud in Vienna, but inevitably Adler professionally disassociated himself from Freud because of theoretical differences. Adler put forth that people created psychological movement through life and moved toward a feeling of significance and belonging (as cited in Ansbacher & Ansbacher, 1956). Style of movement is dictated by subjective lifestyle and private logic, which can be deemed as healthy or unhealthy. Adler claimed that the principle of social interest, or community feeling, could be used as a compass to change and direct a person’s movement in life toward health and satisfaction (as cited in Ansbacher & Ansbacher, 1956).

**Lifestyle**

Adler believed that every expression of an individual, whether it was a thought, behavior, or feeling, was an expression of unity within each person. The principle of unity can be best conceptualized as the lifestyle of the individual. According to Adler’s theory of development, the lifestyle is developed around four or five years of age, prior to sophisticated language and conceptual acquisition (as cited in Ansbacher & Ansbacher, 1956). When a child makes lifestyle decisions, they are without the cognitive abilities to reflect, so the decisions are unsymbolized, void of language, and impervious to criticism and judgment. The lifestyle decision is rooted in creativity made mostly outside of conscious awareness due to the lack of a conceptual structure (Ansbacher & Ansbacher, 1956). The child will assess life conditions, such as his or her place
within a family structure, and develop a fictional goal that persists throughout life. The goal, and the strategy to achieve this goal, is part of the lifestyle. The lifestyle manifests in the decisions and explicit behavior patterns of the individual and the primary cognitive premises that underlie each decision and behavioral pattern (Carlson, Watts, & Maniaci, 2006). According to Adler, the lifestyle most explicitly manifests itself when an individual is confronted with a situation of novelty, difficulty, or resistance. Through the lens of Individual Psychology, when life difficulties arise, the lifestyle guides the individual, mainly unconsciously, through the period of hardship by providing a subjective method to approach problems. In addition, the lifestyle informs an individual’s opinion of oneself and the world and a general attitude toward life itself (Ansbacher & Ansbacher, 1956).

According to Adler, the lifestyle is maintained and more resistant to change as habits, routines, and reactions become more rigid with age (as cited in Ansbacher & Ansbacher, 1956). When confronted with a life problem, an individual is under the impression that he or she is exercising the most viable, effective, and productive option. That is, the person’s lifestyle produced and justified a course toward the goal of moving beyond the difficulty. Adler believed experiences, whether positive or traumatic, are interpreted through the lens of the lifestyle (as cited in Ansbacher & Ansbacher, 1956). In addition, anything that does not comfortably fit into the individual’s worldly attitude is dismissed with little to no consideration because it serves the lifestyle (Ansbacher & Ansbacher, 1956).

Change is possible on multiple levels and the individual can change outward behavior and continue to serve the lifestyle (Ansbacher & Ansbacher, 1956). In contrast, the individual may become aware of the lifestyle that commands and dictates life direction as they consciously move toward improvement According to Carlson et al., (2006), early childhood memories of
specific incidents, or as Adler called them, *early recollections*, are useful tools for increasing an individual’s awareness of the lifestyle. For instance, Adler suggested memories before the age of 10 years can provide valuable information. The memories illustrate unconscious beliefs and negative attitudes that developed in childhood and still have an impact on current behavior. Early recollections are repeated comforting stories and images used to establish a tested and predetermined plan to prepare for future events of distress or conflict (Ansbacher & Ansbacher, 1956). Restructured images from early recollections can be used to motivate individuals toward a desired outcome (Carlson et al., 2006). Instead of imagining failure or danger, individuals can create and construct images and scenarios to move past the problems outside the limitations of lifestyle.

According to Oberst and Stewart (2003), in the third stage of psychotherapy, one of the goals would be to better understand and alter the lifestyle through insight. Oberst and Stewart stated it is not sufficient to understand and observe qualitative lifestyle changes. Along with qualitative lifestyle changes, a conceptualization of how lifestyle manifests must exist as well. The majority of this stage involves effort on the part of the individual refrain from repeated patterns of behavior. An experiential process occurs within the therapeutic relationship when the individual is challenged and confronted by the therapist. Through observation of the lifestyle process, the individual can gain immediate insight as the lifestyle behavior occurs (Oberst & Stewart, 2003).

**Private Logic**

According to Adler, if lifestyle commands the parts of a unified individual, then private logic is ruled by an individual’s lifestyle. Oberst and Stewart (2003) stated every individual has idiosyncratic private logic, and private logic is the antithesis of common sense shared by the
collective group. Private logic provides cognitive reasons for thoughts, feelings, and behaviors. Like lifestyle, private logic is developed in early childhood and is shaped by subjective experience, influencing the individual’s perception of right, wrong, dangerous, safe, etc. through idiosyncratic associations (Carlson et al., 2006). Reality is interpreted through the filter of subjective private logic and creates a personal and unique perception of the individual, relationships, society, and the world; however, Oberst and Stewart stressed that private logic is generally unconscious or hidden from the individual’s awareness.

Adler claimed faulty thinking is the incongruence of private logic and common sense has a negative impact on mental health (as cited in Carlson et al., 2006). Additionally, Adler thought faulty thinking was the root of many of problems. As mentioned before, private logic exists in everyone, but Oberst and Stewart (2003) conceptualized varying levels of how private logic affects mental health: normal, neurotic, and psychotic. Oberst and Stewart stated private logic can dictate the severity of mental illness. The more private logic becomes reality, as opposed to a conscious fiction, the more an individual will move away from common sense. As a result, the potential exists for an increase in the severity of pathological symptoms. According to Adler, when a person is neurotic, they act as if private logic is reality (Oberst & Stewart, 2003). In terms of psychosis, a person will act as if private logic is reality and believe it is reality. To illustrate this concept, Carlson et al. (2006) introduced two statements an individual may say: “I should be number one,” and “I should always be number one, no matter what” (p. 87). Carlson et al. went on to say that both statements contain private logic, but the latter of the two statements contains a degree of hostility, a lack of flexibility, and black-and-white thinking. This type of private logic is called *dichotomous private logic* because it is defined by dichotomies and extremes such as: yes or no, success of failure, and master and slave. The former statement (I
should be number one) is potentially neurotic but does not possess as much potential psychopathology as the latter (I should always be number one, no matter what) because it is more flexible and adaptive (Carlson et al., 2006). According to Oberst and Stewart (2003), through examination of behavior patterns and previous decision-making processes, the individual receiving treatment becomes aware of private logic on an intellectual level. Ideally, the individual comes to realize that past approaches to life’s problems are not functional and do not assist in the useful or constructive achievement of a goal. Oberst and Stewart (2003) stated an individual’s approach to problems is driven by the mistakes in private logic. For instance, mistakes in private logic may come in the form of assumptions, prejudices, and generalizations about the self, relationships, and the environment. It is the role of the therapist to guide the individual to underlying cognitive mistakes that impede functionality (Oberst & Stewart, 2003).

Private logic consists of subjective cognitive constructions that shape the perception of the individual. During psychotherapy, a therapist will attempt to raise an individual’s awareness of the symbolic and metaphoric meaning of the constructions (Oberst & Stewart, 2003). According to Oberst and Stewart, during the reorientation stage of therapy, the therapist engages the client in the process of detailing the mistakes of private logic. The client and therapist work to consciously alter the mistakes so the client can achieve a goal. Carlson et al. (2006) suggested restructuring early recollections can be of use in this stage of therapy. For example, early recollections challenge the individual to think beyond, and step out of, private logic with a prompt to create a different approach to an early childhood memory.

**Significance, Belonging, and Social Interest**

Adler posited that every human innately strives to gain significance in the family, community, and society (as cited by Ansbacher & Ansbacher, 1956). Carlson et al. (2006) stated
there are two ways to create movement and establish significance. *Horizontal movement* toward significance would involve contributing to humanity as a whole and making contributions to the lives of others. Horizontal movement creates group cohesion through communication, compromise, and compassion. Carlson et al. stated every individual in the community is different but equal in the ability to contribute in a subjective fashion when they move toward goals *with* each other and not against each other. Horizontal movement limits the need for safeguarding tendencies and acts of an egotistical nature due to a lack of feeling superior over others (Carlson et al., 2006). In contrast to horizontal movement, during *vertical movement* an individual exercises movement toward significance and is willing to cast aside the needs of others in order to achieve goals, such as power and authority. During vertical movement people perceive others as below or above them, creating a sense of inferiority and superiority within social relationships (Carlson et al., 2006). Striving for significance has transformed into striving for superiority (Oberst & Stewart, 2003). As a result of vertical movement, individuals adaptively rely on safeguarding tendencies and overcompensation of perceived inferiority as seemingly useful tools to be superior over others in the community (Ansbacher & Ansbacher, 1956).

Adler stated in addition to significance, a sense of belonging is innately sought by humans (as cited in Ansbacher & Ansbacher, 1956). When people create horizontal movement toward significance, they contribute to the community’s strength through cohesion and satisfy individual striving for belonging within a group setting (Oberst & Stewart, 2003). That is, during horizontal striving, people attempt to find a place within the community where they are able to balance the need to be a part of the group, contribute, and maintain personal identity. If an individual is striving for significance in a horizontal manner and creating a sense of belonging
for themselves within a social group, then the individual is acting on a positive principle of community feeling, or as Adler referred to it: social interest (Ansbacher & Ansbacher, 1956). According to Adler, difficulties, problems, and moments of distress experienced during an individual’s life have a social root (as cited in Ansbacher & Ansbacher, 1956). Adler believed creating community feeling through social interest was of utmost importance for maintaining an individual’s mental health. Adler believed measuring an individual’s social interest was a fruitful avenue to assess the overall status of mental health (as cited in Ansbacher & Ansbacher, 1956). In addition, Adler believed that when an individual acted in a socially interested fashion (e.g., with concern, compassion, and overall care for others in the community) it would contribute to healthy engagements and relationship with others.

An individual who is not striving for significance and belonging in a socially interested fashion is generally exercising behavior that is determined by lifestyle and justified by mistaken convictions of private logic (Ansbacher & Ansbacher, 1956). That is, the perspective is limited by private logic. When individuals do not act in a socially interested way, they do not see the needs of the community and their role within the community (Carlson et al., 2006). As a result of social interest, a person participates and cooperates in a community and achieves a broader perspective of themselves and the relationships they hold. An individual’s lifestyle is developed early in life, but according to Adler, by adopting the principle of social interest, one can develop and change to increase one’s mental health.

**Post-Traumatic Stress Disorder**

According to *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013), Post-Traumatic Stress disorder (PTSD) is defined as a group of symptoms an individual may exhibit after being exposed to one or more
traumatic events. A person may directly experience the event, witness the event, learn of a
violent or accidental event that a person close to them experienced, or be repeatedly exposed to
the details of the event. Based on the aforementioned possibilities for exposure, traumatic events
take place on a wide spectrum of experience and in a wide range of populations. The traumatic
experience can manifest in many forms, but some of the most common include childhood abuse,
war or combat exposure, sexual assault, acts of terrorism, and natural disasters. By 75 years of
age, it is estimated that 8.7% of the U.S. population meet the diagnostic criteria for PTSD

According to the DSM-5, individuals diagnosed with PTSD will willfully avoid a
stimulus that is associated with the traumatic event (American Psychiatric Association, 2013).
These environmental triggers arouse the conditioned emotional response, and these triggers can
be in the form of objects, people, situations, and activities. If the individual is exposed to a
trigger, then thoughts, memories, or feelings associated with the traumatic event may be aroused,
leading to great distress and discomfort for the individual. The distress can impair the ability to
function in psychological, social, occupational, and physical domains (American Psychiatric
Association, 2013).

According to the DSM-5, PTSD can theoretically occur from the first year of an
individual’s life until death. Diagnosis can take place as early as preschool years to when a
person becomes an older adult; however, there is less prevalence with the very young and older
adult aspect of the age spectrum (American Psychiatric Association, 2013). It is possible
preschool children do not understand the context and the extremity of the traumatic event or that
sufficient diagnostic tools to assess younger children have not yet been developed. Generally,
older adults may have clinical impairments associated with age, such as cognitive deficiencies or
social isolation, so PTSD symptoms may not be easily detected. Those with the highest rate of traumatic exposure are the survivors of horrific events, those with an occupation that involves inherent risk (i.e., police officers, firefighters, and combat personnel), as well as Latinos, African Americans, and Native Americans when compared to U.S. non-Latino whites (American Psychiatric Association, 2013).

**Current Treatment and Interventions**

Treatment and interventions have been developed to reduce PTSD symptoms; however, brief evidence-based PTSD treatment models are unavailable for utilization by standard mental health clinicians (Possemato et al., 2011). Mindfulness-based stress reduction (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010), cognitive processing therapy (Schumm, Dickstein, Walter, Owens, & Chard, 2015), prolonged exposure therapy, (Berenz, Rowe, Schumacher, Stasiewicz, & Coffey, 2012), and trauma management therapy (Beidel, Stout, Neer, Frueh, & Lejuez, 2017) may be used to manage trauma-related symptoms. In addition, other complementary and eclectic treatments exist to assist clients diagnosed with PTSD.

**Mindfulness-based stress reduction.** The goal of mindfulness is to help clients develop necessary skills to effectively cope with the distress of trauma-related thoughts and feelings (Powers et al., 2010). Additionally, mindfulness is typically the treatment of choice when treating PTSD. In fact, 88% of PTSD programs at Veteran Affairs utilize some sort of mindfulness intervention (Libby, Pilver, & Desai, 2012). Clients learn to cultivate awareness from moment to moment (Possemato et al., 2016). The client is aware of thoughts, emotions, and behaviors in a non-judgmental, open, and accepting fashion. Possemato et al. stated the goal of mindfulness practice is to focus on the present moment regardless of the experience. By increasing focus and attentive control, clients are better able to master intrusive and distressing
thoughts and emotions associated with PTSD (Possemato et al., 2016). Mindfulness-based stress reduction (MBSR) is a 26-hour protocol used to develop mindfulness through meditation, yoga, psychoeducation, and group discussion. When compared to standard PTSD treatments, researchers found mixed results regarding MBSR’s efficacy; however, the researchers suggested that MBSR is equally effective in treating PTSD as the current standard treatments (Possemato et al., 2016).

**Cognitive processing therapy.** Cognitive processing therapy (CPT) focuses on the negative cognitive activity of an individual diagnosed with PTSD. Based on a social-cognitive theoretical model, CPT is an empirically supported treatment (Schumm et al., 2015). Negative cognitions could include a pessimistic view of the world, self-guilt or blame about the traumatic event, or an overall negative self-image (Schumm et al., 2015). Within the CPT treatment model, the belief is that negative thoughts initially assist in the development of PTSD symptoms and maintain the symptoms through repeated and reinforced patterns of thinking. According to the CPT treatment model, a distressing emotion is associated with the negative cognition. For example, if an individual believes he or she is to blame for the traumatic experience, guilt and sadness become associated with that negative cognition (Schumm et al., 2015). Cognitive processing therapy is a 12-session psychotherapy protocol used to modify the negative cognitive patterns. Although there is no definitive evidence to show that CPT effectively treats PTSD, research suggests that it does decrease the amount of dysfunctional cognitions throughout therapy (Schumm et al., 2015).

**Prolonged exposure therapy.** Prolonged exposure therapy (PE) is a cognitive-behavioral approach to treating the symptoms of PTSD. Prolonged exposure therapy includes the use of psychoeducation, breath work, and exposure to a stimulus in vivo as well as in the imagination.
Berenz et al. (2012) suggested that 12 sessions of PE can effectively reduce some symptoms of PTSD. During PE, clients are repeatedly exposed to distressing situations or stimuli associated with the traumatic event. Through a systematic and methodical approach, the distressing situation is engaged until the anxiety or fear associated with the situation diminishes (Berenz et al., 2012). The therapist and patient decide what situations are inherently and conventionally safe, yet evoke fear in the patient because of an association to the traumatic event (e.g., going to a grocery store where a shooting took place). In some cases of exposure, the most distressing narrative of the traumatic event is audio recorded and the patient is required to listen to the recorded narrative during the entire session. During PE therapy, the assumption is that the exposure allows for emotional processing of an event that has been avoided and repressed (Berenz et al., 2012). Individuals going through the PE protocol are given practical coping tools to lessen the intensity of the repeated exposure (Berenz et al., 2012). In addition, psychoeducation is implemented to give information to the client about the PTSD diagnosis and the PE treatment model. Breathing techniques are used to mitigate anxious feelings during the repeated exposure. Datum suggests that PE is one of the most effective treatments for PTSD (Foa, Keane, Friedman, & Cohen, 2009); however, when used as a single intervention with combat veterans, it is insufficient in treating PTSD (Beidel et al., 2017).

**Trauma management therapy.** Trauma management therapy (TMT), a relatively new therapy protocol, is targeted specifically toward treating combat-related PTSD. Trauma management therapy was originally developed in the mid-1990s and included behavioral principles to approach PTSD symptoms in a unique fashion (Beidel et al., 2017). Rather than great emphasis on positive symptoms such as depression and anxiety, TMT addresses negative symptoms and behaviors, such as anger, isolation, and lack of affect through specific
interventions (Beidel et al., 2017). Allegedly, the multicomponent lens of treatment contributes to the effectiveness of TMT. That is, a treatment approach that includes a wide array of symptoms would be appropriate for the complex and multilayered PTSD diagnosis (Beidel et al., 2017). Through a skills-based approach, TMT integrates individual exposure therapy (similar to PE) and every client’s situation is uniquely addressed. Depending on the characteristics of the traumatic event, appropriate exposure techniques will be used. Beidel et al. stated skills are developed in a group format to facilitate social and emotional rehabilitation. Utilizing a two-pronged approach, TMT concurrently treats the positive symptoms of PTSD with individual exposure therapy, and the negative symptoms with a skills-based approach. Beidel et al. (2017) suggested that patients who participated in the TMT protocol were more likely to have increased social interactions when compared to the control group. Social interactions reduced negative symptoms (e.g., anger, isolation, lack of affect) and this can be attributed to the defining characteristic of TMT: social and emotional rehabilitation.

**Complementary and eclectic treatments.** It has become common practice to combine multiple treatment protocols to reduce the symptoms of PTSD. In fact, two thirds of Veterans in a large military cohort received one or more complementary treatments for PTSD in addition to primary treatment (Jacobson et al., 2009). It appears to be beneficial to combine PTSD treatments to address the vast array of symptoms the pathology exhibits. Generally, the primary treatment is a type of exposure therapy with an appropriate complementary cognitive or skill-based approach. For example, Paunovic and Ost (2001) and Foa et al. (2005) combined cognitive restructuring with prolonged exposure therapy, and Foa et al. (1999) combined prolonged exposure therapy with stress inoculation therapy in a research setting. The treatments alone are efficacious, so it would seem theoretically possible that a combination would
compound the positive effects of treatment; however, the aforementioned researchers did not conclude that the combined treatment models enhanced the treatment outcomes. In contrast, Bryant, Moulds, Guthrie, Dang, and Nixon (2003) suggested combining treatments enhanced outcomes compared to a single treatment. Bryant et al. combined cognitive restructuring and exposure therapy, but unlike the other studies, imaginal exposure was utilized and not in vivo exposure as well. Research is inconclusive regarding the effectiveness of combining two or more treatment methods, but there are two possible reasons for the inconclusive results. According to Foa et al. (2005), by combining two separate treatments into one program, it is possible that the subjects do not receive the full range of both treatments. Second, the treatments may be addressing the same negative, symptomatic cognitions exhibited by the subjects (Foa et al., 2005).

There are many options for effectively treating PTSD, but, unfortunately, brief evidence-based protocol does not exist. As a diagnosis, PTSD offers clinical difficulty and complexity. Whether it is the non-discriminatory age range in the diagnosed population, the wide range of idiosyncratic traumatic experiences, or the vast number of potential symptoms, treating PTSD is a difficult clinical task with no clear path for establishing efficacy.

**Trauma and Dreams**

The relationship between trauma and dreams is paradoxical and complicated (American Psychiatric Association, 2013). Depending on which field of study is conceptualizing the term “dream,” one may come across two very different ways of perceiving the nocturnal experiences during sleep. For instance, a dream is conceptualized as an intrusive symptom in regard to PTSD, but at the same time, according to dream research, a dream is viewed as a possible adaptive mode for processing emotional events (Phelps, Forbes, Hopwood, & Creamer, 2011).
Can dreams be intrusive and negative, yet be powerful mechanisms for processing emotionality? To most individuals, dreams are inconsequential, but to those who suffer from the symptoms of PTSD, dreams can mimic or symbolically represent the experience of a traumatic event that stirs fear, terror, and distress in the mind of the individual (Phelps et al., 2011).

Dreams, in the form of trauma-related dreams, are a diagnostic symptom of Post-traumatic stress disorder (American Psychiatric Association, 2013). The diagnosis requires a single re-experiencing symptom, commonly in the form of an intrusive memory during the daytime, but a recurring dream will meet this diagnostic requirement (Phelps et al., 2011). Distressing dreams are typically recurrent and at times the initial traumatic event is re-experienced or replayed (American Psychiatric Association, 2013). According to the DSM-5 (American Psychiatric Association, 2013), an individual may dream of the actual content of the traumatic event. He or she may experience an associated effect as a result of the dream—even if the dream is void of content from the traumatic event. The content of the dream, as well as the associated emotion, (i.e., fear, guilt, or shame) are equally valuable in the understanding of the relationship between trauma and dreams.

**Content of Trauma-Related Dreams**

The diagnostic criterion for PTSD requires a recurrent experience of re-experiencing the trauma (American Psychiatric Association, 2013). The re-experiencing of the event manifests as an experience of sensation (i.e., sensory fragments of sound, color, or movement perceived by the individual). It is not a re-experiencing of the event via the individual’s narrative or inner monologue, but a vivid, realistic, detailed depiction of the traumatic event that results in somatic reaction (Phelps et al., 2011). In the case of an intrusive memory, the individual generally re-experiences a short fragment of the traumatic experience, but in the case of dreams, the
individual is subjected to lengthy, elaborate, and sophisticated storylines and scenes (Phelps et al., 2011). The dreamer can figuratively step into the traumatic event and re-experience the event in its entirety. In fact, the dream may present a conclusion to the event that is more horrific and fear-inducing than the initial traumatic event (Phelps et al., 2011).

Attempts at categorizing the dream content have been made to better understand the relationship between trauma and dreams. Brenneis (1994) described two types of relationships between trauma and dreams: isomorphic and homomorphic. The isomorphic relationship is when the dream content replicates the initial traumatic experience. The homomorphic relationship is when the dream content has no perceivable association to the traumatic experience. Dreams not only manifest as replicated experiences of the initial traumatic event, but can be re-experienced in varying forms.

Phelps et al. (2011) developed three categories of trauma-related dreams: replay, mixed, and non-replay. The replay type is an exact account of the traumatic event in full sensory detail. The mixed type, contains content that is derived from the initial traumatic experience as well as content that is not associated to the traumatic event. The third form, the non-replay type, does not include content that can be directly associated to the initial traumatic event, yet the emotional and affective reaction the dreamer has to the dream (i.e., fear or guilt) is similar to the reaction during the initial traumatic event. For the purpose of diagnosing PTSD and finding suitable treatments for symptoms of trauma-related dreams, non-replay dreams that result in the associated emotion must be considered a re-experience of the traumatic event (Phelps et al., 2011). Even though no content from the initial experience is present in the dream, the dreamer experiences an intense and severe emotional reaction to the dream that impedes functionality and
overall well-being. Research and the dream types developed by Phelps et al. (2011) support the diagnostic idea that both content and effect are of significant, if not equal, importance.

**Effect of Trauma-Related Dreams**

Intense emotionality accompanies a trauma-related dream (American Psychiatric Association, 2013). As stated above, the content of the dream may replicate the traumatic experience, but the experience of the dream itself may cause significant emotional distress to the dreamer in the form of fear, guilt, helplessness, anger, sadness, or other negative emotions (American Psychiatric Association, 2013). Phelps et al. (2011) found that fear was associated with 75% of reported dreams, (replay, non-replay, or mixed type) and was the most commonly associated emotion in dreams—followed by helplessness and despair. Phelps et al. (2011) suggested that the emotional effect of the dream may not be the same as the experience during initial traumatic event. One would assume that it would be the same and simply transfer the emotion into a dream experience; however, some individuals experience no emotion during the initial event (Phelps et al., 2011). Phelps theorized that the individual suppresses the reactive emotion to the event for reasons of survival (e.g., a soldier during wartime, or the inability to conceptualize the severity of the situation). There can be a delay or transformation of affect following the traumatic event. For example, a person may not have a reaction during the initial traumatic event and after a dream, feel guilty for surviving. Almost half (46%) of the subjects in a study by Mellman et al. (2001) reported intense emotionality in trauma-related dreams within days of the traumatic experience.

**Purpose of Trauma-Related Dreams**

**Emotional processing.** Trauma-related dreams are a symptom of a PTSD diagnosis, so it would make sense to investigate the possible purpose of the dreams. Mellman et al. (2001)
suggested that individuals who reported distressing trauma-related dreams exhibited more severe concurrent symptoms of PTSD than those individuals who are unable to recall, or do not experience distressing dreams. The purpose of trauma-related dreams has been researched for decades. Greenberg, Pearlman, and Gampel (1972) hypothesized that distressing dreams were unsuccessful attempts by the ego to effectively adapt, master, and integrate the traumatic experience into consciousness. The study led to inconclusive results to support the hypothesis. Hartmann (1998) proposed dreams served to contextualize the emotional concerns of the individual in a sleep-induced environment. Mellman et al. (2001) sought to elaborate on the previous hypotheses and suggested that when dreams follow a traumatic event, they may aid in emotional adaptation. In addition, Mellman stated because dreams depict, and sometimes replicate, a traumatic experience as an intense sensory experience, the purpose of a dream is consistent with emotional processing theory.

**Memory assimilation.** Hartmann (2010) suggested the emotionality of a dream provides the dreamer with information or “tells” them what is of importance when recalling memories and dreams. Hartmann stated memories are more easily recalled when they are associated with emotion, and that dreams selectively incorporate intense emotionality to guide the dreamer in framing what is, and what is not, an important or impactful event. It is as if the emotion is a beacon for measuring the psychological relevance of the memory. Malinowski and Horton (2014) further investigated and found that the emotion of a dream may somehow be correlated with measuring subjective importance. Malinowski and Horton proposed emotional memory assimilation theory and suggested that emotion in dreams may unconsciously provide information on the importance of events in waking life. Based on the level of emotion, the individual may or may not assimilate the event into a memory system. Malinowski and Horton
concluded that emotions are, in fact, a mechanism for automatically guiding and deciding which events in waking life will be integrated during sleep into long-term memory.

**Threat simulation theory.** According to threat simulation theory, dreams serve an adaptive, evolutionary function (Revonsuo, 2000). Zada, Desjardins, and Marcotte (2006) studied whether dreams simulate threatening events to prepare an individual for an actual threatening experience. It is as if the dream is a rehearsal for the waking event, and the dreamer can practice behaviors to avoid the threat in dreams. Zada et al. found that 66% of recurring dreams contained some form of an immediate threat to the dreamer and the dreamer would take definitive action to deter, mitigate, or evade the threat. Participants reported that most of the dreams did not include realistic or probable threats. That is, the dreams were not directly applicable to threats in the dreamer’s waking life. In fact, dreamers were unsuccessful in avoiding or fleeing danger, thus the simulation of the threat did not provide useful and practical threat-avoidant behaviors. After mixed results, Zada et al. found inconclusive evidence to support threat simulation theory as a function of dreams.

Valli, Revonsuo, Pälkäs, and Punamäki (2006) studied the dreams of Palestinian children who had experienced traumatic events in comparison to those who had not experienced traumatic events. Valli et al. sought to test threat simulation theory and hypothesized that when a child was exposed to traumatic and threatening events, the child would experience a higher frequency of dreams and an increased level of threat in the dreams. Valli et al. suggested that the children exposed to traumatic events had a higher frequency of dreams, but the intensity of the threats in the dreams did not differ significantly between the two groups. Valli et al. speculated that the control group experienced a similar level of threat in dreams because they vicariously and
indirectly experienced the trauma through the stories of their parents, the media, and other cultural channels.

Research conducted on the relationship between trauma and dreams illustrates that dreams may assist in the emotional processing of a traumatic event, aid in the assimilation of the dream into memory, or help an individual prepare for future traumatic events (Hartmann, 2010; Mellman et al., 2001; Revonsuo, 2000). Recurring trauma-related dreams are a symptom of PTSD and when dream functions do not serve a purpose, the dream may decrease an individual’s overall functionality and mental health (American Psychiatric Association, 2013).

**Current Use of Dream Work**

Dreams are generally associated with the psychodynamic orientation of psychotherapy (Hill et al., 2013). The use of dreams in classical Freudian and Jungian circles continues, but those outside of the psychodynamic orientation currently find the usefulness of dreams to facilitate healing and treatment (Hill et al., 2013). Orientations ranging from cognitive-behavioral therapy to group therapy incorporate dream work in clinical practice.

According to Hill and Knox (2010), cognitive therapists use dreams as a component of homework to establish tasks for cognitive-behavioral therapy (CBT) clients. Hill and Knox stated CBT therapists refer to a protocol that contains 15 guidelines when they use dreams in the therapeutic setting. Rather than approach dreams in a symbolic manner, CBT therapists use the overarching theme of the dream as reality that is consistent with waking life (Hill & Knox, 2010). It is the job of the CBT therapist to assist the patient with connections between dream images and waking life. Hill and Knox stated CBT therapists use dreams when a client is “stuck” because the dream may present an overlooked moral or ethical issue of importance to the patient.
Sparrow and Thurston (2010) used the five star method to work with dreams. This phenomenological method focuses on the relation of the dreamer to the dream. As opposed to interpreting the dream as a collection of static symbols, the primary goal is to examine the dreamer’s responses in the dream. The response in the dream defines the dreamer’s style used to relate to the dream itself (Sparrow & Thurston, 2010). According the five star method, the dreamer and dream are autonomous agents which allow the dreamer to have a sense of agency in how dialogue is created within the dream. The dreamer can then take that relational knowledge and apply it to interpersonal and intrapersonal relationships in waking life (Sparrow & Thurston, 2010). The dream is stripped of all personal and descriptive connotations to reduce the dream to a simple narrative statement. Together, the dreamer and therapist examine points in the dream where the client responded in a fashion that would affect the outcome of the dream, whether it was emotional, cognitive, or behavioral. At that point, the response would be discussed with the dreamer, and the client would determine if the dream response is the habitual response to similar situations in waking life (Sparrow & Thurston, 2010).

Swan and Schottelkorb (2013) utilized sandtrays and to better understand the dreams and inner experience of children. Children are able to recall dreams by the age of 3 years old, so the sandtray method for someone with limited linguistic capabilities is of value (Swan & Schottelkorb, 2013). A sandtray allows a child to recreate a dream world with toys, which allows the child to experience a dreamlike state. Swan and Schottelkorb (2013) believed the process of constructing the dream world via the sandtray is healing, since it does not require the therapist to interpret words or metaphors. It is almost as if the dream is taking place directly in front of both the child and therapist. A sandtray for interpreting childhood dreams (SICD) intervention, created by Swan and Schottelkorb (2013), is used to assist children in exploring
thoughts and feelings outside of awareness and understanding regarding the impact of those thoughts and feelings during waking life. Children are asked to use meditation to conjure the dream, recreate the dream using the sandtray, describe the dream scene and feelings associated with it, and then draw meaning from the dream and title it as they see fit. The effectiveness regarding the use of SICD for pathology or behavioral issues has not yet been established (Swan & Schottelkorb, 2013).

Most dream work is conducted with individual clients, but groups are used as a way of sharing and understanding dreams with multiple perspectives from both mental health professionals and non-professionals (Hill & Knox, 2010). Generally, a member of the group will share a dream, answer clarifying questions about the dream content from other members, listen to other group member’s personal associations, and then share any other thoughts they have developed while other members were speaking. The group approach emphasizes safety and control, allowing the member who is sharing the dream to withhold intimate information or discontinue the process at any time (Hill & Knox, 2010). Hill and Knox stated that psychodrama may be used to create a scene and characters from one of the member’s dreams. Each member would play the role of a character or symbol in the dream using subjective associations. This approach is similar to the aforementioned group approach, but members are encouraged to act out and interject associations more explicitly. After the scene, the dreamer is asked to document the experience of the process itself and not the thoughts on the specific dream content (Hill & Knox, 2010).

Elliot (2012) proposed that the Gestalt approach to dream work would coincide greatly with the cultural values and traditions of Aboriginal peoples in Canada. In Aboriginal culture, dreams are viewed as carriers of important messages that establish a connection or dialogue with
the spirit world. Gestalt dream work views seemingly individual problems through the lens of the entire environment. Elliot claimed a Gestalt approach is appropriate for Aboriginal culture because, if properly applied, it would take into consideration intergenerational Aboriginal trauma experiences such as poverty, colonization, and loss of culture. The narrative nature and visual representations used in a Gestalt approach is similar to how Aboriginal people relate to surroundings and derive meaning from dreams. As a result, complex ideas and relationships can be expressed—even in a mental health setting.

Psychotherapists are now taking into greater consideration the cultural perspective of dreams and the value of dreams in treating symptoms of PTSD (Schubert & Punamaki, 2016). Schubert and Punamaki utilized dream work in psychotherapy with two women suffering from symptoms of PTSD. One woman was from West Africa and the other was from the Middle East. The cultural perceptions of the dreams had an influence on how the women perceived the dreams. For example, in West Africa, the dream may be a connection to the spiritual world or in the Western culture dreams may represent the dreamer’s inner state. For this reason, dream work must respect the cultural influence regarding recurrent dreams. Schubert and Punamaki (2016) stated that those who experience recurring trauma-related dreams often see cultural healers; however, Schubert and Punamaki found that the two females were skeptical of psychotherapy and reluctant to share dreams. After months of dream work and building trust in a psychotherapeutic setting, both women reported a reduction of PTSD symptoms, including trauma-related dreams, anxiety, and co-occurring substance abuse.

According to Spangler and Hill (2015), the cognitive-experiential dream model (CEDM) is a highly effective intervention that utilizes the most impactful treatment elements of dream work. By exploring dream material, deriving meaning from the dream, and creating an action-
based plan appropriate to the meaning of the dream, the CEDM method may help the client develop insight and understanding (Spangler & Hill, 2015). A majority of the CEDM session takes place exploring dream material (Kline & Hill, 2014). Spangler and Hill stated that the methodical and clear structure of the approach allows for the construction of training protocols and replicability for research. In fact, CEDM is the only dream model that has gained empirical validation in a research setting (Hill & Knox, 2010). Tien, Chen, and Lin (2009) studied the CEDM approach in Taiwan to establish the client’s perspective regarding the most helpful components of CEDM. Tien et al. stated the participants found the associations to waking life, self-exploration, insight development, and action-based ideas to be the most beneficial components of CEDM. All four of these components are addressed in the CEDM approach.

Spangler (2014) utilized nightmare deconstruction and reprocessing (NDR) as a relatively new therapeutic tool to potentially treat the symptom of trauma-related dreams for PTSD. The goal of NDR is to reduce fear response through exposure and emotional processing, construct meaning and reprocess feelings associated with the event, examine maladaptive beliefs, and recreate a script for the nightmare (Spangler, 2014). An American veteran with a diagnosis of PTSD, who served in the war in Afghanistan, was used as the subject in a case study. Datum from the study suggested that the subject’s PTSD symptoms decreased. In addition to higher sleep quality and an optimistic perspective of dreams, the subject experienced a reduction in waking-life symptoms, including decreased sensitivity to his surroundings and decreased patterns of avoidance (Spangler, 2014).

**Discussion**

Dream-based interventions, such as the cognitive-experiential dream model (CEDM) and nightmare deconstruction and reprocessing (NDR), provide promising empirical support for the
use of dream work as a treatment for pathological mental health symptoms. The applicability to the trauma-related dream symptoms of PTSD cannot be overlooked. From a clinical perspective, the distressing, re-experiencing of the traumatic event in the form of a dream should be the target symptom for treatment. Trauma-related dreams have a significant impact on basic cognitive, emotional, and social functioning. Trauma-related dreams are a predictor of more severe symptoms of PTSD (American Psychiatric Association, 2013); therefore, psychotherapists should begin to treat symptoms of PTSD by starting with what could be seen as the nucleus of distress, emotionality, and re-experiencing of the event: the dream.

Past conceptual frameworks and current interventions provide the foundation for creating a thorough and effective protocol for those suffering from PTSD and trauma-related dreams. By drawing on concepts, theories, and research conducted and developed over the past 100 years, psychotherapists are more than able to develop a language that can be adopted by the mental health field when addressing dream-based interventions. Past research includes the effectiveness of dream-based interventions with PTSD and other pathology (Hill & Knox, 2010; Schubert & Punamaki, 2016; Spangler, 2014; Spangler & Hill, 2015). An integrated treatment approach that effectively addresses the cognitive, emotional, and social aspects of trauma-related dreams and PTSD is needed. Various interventions and treatments do reduce some of the symptoms of PTSD, but by addressing the trauma-related dreams using modern dream work practices, in combination with specific concepts of Individual Psychology, a potentially new and effective approach can be developed. The utilization and integration of Adlerian concepts (Ansbacher & Ansbacher, 1956) into current dream work practices may address and treat both the trauma-related dream symptom and the waking-life symptoms of patients suffering from PTSD.
Alfred Adler’s Individual Psychology (Ansbacher & Ansbacher, 1956) is an appropriate theoretical orientation to address the symptoms of PTSD, specifically the symptom of trauma-related dreams. Adler proposed that dreams are an expression of an individual’s lifestyle, and that they are plagued with mistaken convictions supported by private logic (Lombardi & Elcock, 1997). Adler did not provide an abundance of literature regarding the role of dreams in the process of psychotherapy, but there are basic principles and concepts of Individual Psychology that can be expanded upon to create the conceptual foundation for a PTSD treatment protocol, particularly for those suffering from the trauma-related dream symptom. Adler’s concepts of private logic, lifestyle, and social interest are of value when examining the wide range of complex symptoms exhibited in PTSD. Individual Psychology addresses cognitive distortions via the concept of private logic, how an individual perceives and approaches problems via the concept of lifestyle, and a person’s place within the community via the concept of social interest (Oberst & Stewart, 2003).

Clients suffering from PTSD symptoms generally exhibit negative thinking patterns regarding their role or relationship to a traumatic event. For example, the individual may feel as if they are responsible for causing the event, that they are a person of lesser character because of the traumatic event (e.g., sexual assault), or experience guilt for surviving when others did not survive. By increasing intellectual awareness of the private logic that justifies the individual’s mistaken thought patterns and associated negative emotional response, an individual may begin to understand the purpose as to why they practice negative thought patterns. As a result, the associated emotion loses control over the individual.

The concept of lifestyle can be applied to how the individual attempts to solve the problem of distress caused by trauma-related dreams. An understanding of lifestyle, which
commands private logic, can be done through the examination of waking-life responses to dreams and the responses within the dreams. After an understanding of private logic and lifestyle has been developed, then the individual can actively and consciously work to change the usual responses to situations, and utilize the concept of social interest as the guiding principal for future responses and action-based plans.

**Implications for Practice**

Foundational concepts of Individual Psychology can be used as guiding principles to develop a protocol that utilizes modern dream-based interventions to effectively treat the PTSD symptom of trauma-related dreams and potentially, waking-life symptoms such as negative cognition and isolation (Ansbacher & Ansbacher, 1956; Beidel et al., 2017; Spangler & Hill, 2015). A 12-week protocol that involves an individual and group therapy format could provide the understanding, emotional support, and social connectedness needed to heal from trauma and move beyond the distress of trauma-related dreams.

**Introduction.** The first stage of treatment would involve meeting the therapist or therapists in an individual session. The goal of this step would be to build trust, safety, and security between the client and the therapist. Every client has a unique experience, story, and perspective on trauma and related dreams, so this time would allow the therapist to conceptualize and get to know the client’s story in the privacy and comfort of an individual session. The therapist would complete a thorough assessment to examine mental health history and current symptoms. In addition, the therapist would ensure the client is a proper fit for the treatment. In some instances, such as those clients with severe co-occurring pathologies with psychotic features, the group process may not provide significant therapeutic benefit. If the client is an
appropriate fit for dream work within a group, then the process, expectations, and potential benefits and risks of the protocol are explained to the client.

The client will be taught to properly record and report their dreams and directed to keep a dream journal or voice recorder next to the bed. Clients will be instructed to journal all dreams with as much detail as possible. In order to best capture the dream experience, clients will be asked to record the dream in the present tense. In the case of this diagnostic population, the clients will more than likely have recurrent dreams, but will be asked to share the most recent recurrent dream.

**Record and share the dream.** The therapist and the clients will meet in a group setting with four to eight participants. The group format is intended to promote a feeling of community through the concept of social interest (Ansbacher & Ansbacher, 1956). Through communication, compassion, and compromise, group members are able to relate to those with similar traumatic experiences. Similar to the TMT, the patient will be able to develop practical social skills, in addition to insight, by addressing the negative symptoms of PTSD, such as isolation. Members can develop social skills to promote healthy relationships in and out of the group as well as confront and prevent social behaviors that lead to the negative PTSD symptoms of isolation and loneliness. As suggested by Beidel et al. (2017), groups that promote social rehabilitation are more likely to have increased social interactions outside of treatment.

Trauma-related dreams have a negative impact on an individual’s cognitive, emotional, and social functioning (American Psychiatric Association, 2013), so the target symptom for every client is trauma-related dreams. With a focus on that specific symptom, a sense of group purpose is developed and a clear goal is defined. After a brief mindfulness practice to bring members into the present moment and a personal check-in, a client will share a recent trauma-
related dream. As in the recording of the dream, the patient will share the dream in the present tense. If at any point in the process the patient would like to discontinue sharing because of distress or intense emotionality, then the group will move on to another client. After sharing the dream, other group members will have time to ask any clarifying questions about the dream content or experiences in waking life.

**Exploration of dream content.** All group members share personal associations to the dream content and the overall theme. Based on prior research (Schubert & Punamaki, 2016), it is important to respect an individual’s subjective experience and cultural background when listening to personal associations. As stated by Adler, subjective experience influences and shapes private logic and vice versa (Ansbacher & Ansbacher, 1956). Every individual will have a unique association to dream content that is influenced by private logic. The image of a bottle in a dream could represent various meanings, but the dreamer must develop his or her personal meaning. Adler believed that dreams were a metaphor for a waking problem (Lombardi & Elcock, 1997); therefore, each individual group member will have a potential metaphor based on private logic. When the clients listen to the dream associations from other group members they may hear an association that resonates with them and that they can relate to. By verbalizing the dream and their own associations, clients may gain insight into private logic based on the associations with dream content present in waking life.

**Meaning and metaphor.** Deriving meaning from trauma-related dreams is one of many objectives of the dream group. While most of the group time will be used to explore dream content and personal associations, creating meaning from a distressful dream experience may provide fruitful insight into the dreamer’s private logic and lifestyle. With gentle guidance from the therapist and other group members, the client can begin to construct a metaphorical
connection between the dream experience and a conflict, problem, or goal in waking life. Themes between dreams and waking life arise and private logic can be better understood. Through personal associations, the client can compare underlying private logic to other associations and understand the variance in perceptions. Once an understanding of the dream is accomplished, negative thinking patterns and dichotomous convictions may manifest such as, “all men are dangerous,” “everyone in my life ends up in pain,” or “I am not worthy of being loved.”

According to Lombardi and Elcock (1997), lifestyle directly expresses itself in dreams. Like Adler’s concept of early recollections, the fashion in which the client navigates through conflict, danger, tension, difficulty, and novelty within the dream is useful when examining lifestyle. It is as if the overall theme and emotion of the dream is a macrocosm for how the client approaches a trauma-related experience. As mentioned earlier, dreams may serve the purpose of emotionally processing trauma, and a recurring dream persists due to an inability to properly process and integrate the experience into conscious awareness. It may become apparent that the dreamer is practicing safeguarding tendencies and defensive behaviors that do not serve the client in a useful manner. Safeguarding tendencies may manifest in the dream as running or hiding from the dangerous element. By deriving meaning from the dream, clients may gain new perspective on the trauma-related dream or the traumatic event. That is, clients form a new perspective through an understanding of how they approach distress via lifestyle and identify underlying mistaken thinking patterns. At that point, the client has a better understanding of the purpose behind thoughts, emotions, and behavior. This step in the proposed protocol is similar to Adler’s therapeutic stage of insight (Oberst & Stewart, 2003), where one has gained
knowledge and awareness of private logic and lifestyle, yet the greatest therapeutic benefits lie ahead with applying this knowledge to changing lifestyle in a conscious and effortful fashion.

**Reconstruct and reprocess.** By reconstructing and reprocessing the dream, the client can begin to consider and construct alternative approaches to trauma-related dreams and waking-life experiences. If the previous step of creating meaning illustrates the client’s *current* lifestyle, this step will crystallize the client’s desired *changes* to lifestyle. Drawing on ideas put forth by NDR (Spangler, 2014) and the dream work model in narrative therapy (Findlay, 2016), clients examine a course of action within the dream, strictly assess the effectiveness of the approach, and determine whether it is in line with subjective values and goals. Clients can then consider alternatives to the responses and actions within the dream and transform the images, narrative, and theme of the trauma-related dream. Additionally, the client may draw on other responses and actions that were effective in the dream to either increase, intensify, or modify the use of the responses and actions. Once again, trauma-related dreams can be treated in the same manner as Adler’s use of early recollections (Carlson et al., 2006). By restructuring images harmonious with the client’s desired outcome, the client can psychologically move beyond the distress or problem with an approach that is outside the limitations of lifestyle and private logic. For example, if an individual is running or hiding from a seemingly dangerous element in a dream, then the reconstructing and reprocessing stage could be helpful in transforming the dream into a situation where the client confronts the danger with courage, patience, and a sense of choice.

**Create an action-based plan.** Implementing an action-based plan is a step to foster psychological change within the client and exercise the principle of social interest in the community. Using knowledge and insight gained about private logic, lifestyle, and trauma-related dreams, clients develop a plan to implement outside of the therapeutic setting. This plan
would be similar to the last step in CEDM (Spangler & Hill, 2015). The action may come in the form of a ritual, getting involved in a social cause, volunteering, or re-establishing connections with friends and family. Regardless of what the action-based plan is, it must reflect the desired change in lifestyle and have the intent of cultivating a sense of community feeling. Clients will be expected to strive for a sense of significance and belonging in a horizontal fashion void of personal pursuits of power and self-serving behavior. From the beginning of treatment, the group format of the proposed protocol addresses issues of isolation and loneliness through communication, compassion, and social connectedness. Upon conclusion of the treatment, clients can carry what they learned in the group setting out into the community and exercise social interest.

**Recommendations for Future Research**

The current use of dreams, granted limited and sparse, and promising empirical support provides hope for the utilization of dreams in a psychotherapeutic treatment approach; however, more robust, and thorough research should be conducted to investigate the effectiveness of dream-based interventions to decrease pathological symptoms. Many of the studies conducted with dream-based interventions included small sample sizes, differing approaches for implementing dream-based interventions, and lacked control groups. Dream-based research has not been replicated on a larger scale. A larger sample size could be used to test the validity of the previous findings from smaller samples.

The aforementioned protocol does address the cognitive, emotional, and social elements of the trauma-related dreams and PTSD, but it is lacking one seemingly effective experiential element in the treatment of PTSD: exposure. The experience of a trauma-related dream is not considered therapeutic exposure but merely a symptomatic re-experiencing of the traumatic
event. Prolonged exposure therapy has effective results when used as PTSD treatment and it could be used as a complementary treatment in the proposed protocol. If the two treatments were to be used in conjunction with each other, then trauma-related dreams and other PTSD symptoms could be addressed on a cognitive, emotional, social, and experiential level.

Further research should be done on the effectiveness of dream-based interventions with particular populations and varying types of trauma. Trauma-related dreams related to combat or war trauma may necessitate a different treatment approach than dreams related to past experiences of sexual abuse or neglect. Population is of importance, and to generalize the wide array of traumatic experiences into one protocol seems reckless, irresponsible, and naïve. Cultural factors of various populations should be taken into consideration as well. Some individuals do not openly discuss dreams or inner states with strangers because of cultural background. Future research could include how to establish trust and honesty in an efficient and respectful manner with those reluctant to share or discuss trauma-related dreams. The proposed protocol would require a certain level of linguistic ability and intellect to participate in the therapeutic process. Children do not necessarily have the linguistic conceptualization to express dream content and the associated feelings they have regarding it. Other means of implementing dream-based interventions with children, such as sandtrays or art therapy, should be explored to expand the usefulness and flexibility of dream-based interventions to other populations.

**Conclusion**

With the vast number of conceptual frameworks and research conducted on dreams, datum suggests that dream-based interventions can be effectively utilized in a clinical setting to address pathology (Hill & Knox, 2010; Schubert & Punamaki, 2016; Spangler, 2014; Spangler & Hill, 2015). Additionally, a paradoxical relationship between dreams and trauma has been
established, so it would seem that dream-based interventions could be of value when implemented in a PTSD treatment protocol in a clinical setting. Integration of current dream-based interventions with concepts of Individual Psychology allow for a potential protocol to be developed that specifically targets the re-experiencing of the PTSD symptom of trauma-related dreams. By giving special attention to trauma-related dreams from a cognitive, emotional, and social perspective, concurrent waking-life symptoms of PTSD may also be treated.
References


Spangler, P. T. (2014). Nightmare deconstruction and reprocessing for trauma-related


