The literature on post-traumatic stress disorder describes recurrent nightmares as a symptom of post-trauma adjustment difficulties. Because nightmares frequently represent unresolved conflict from past catastrophic event(s), they merit consideration as a direct part of counseling and therapy. In this article the author presents information on nightmare therapies to include treatment strategies, techniques, and descriptive accounts of implementations. The case histories are gathered from a population of combat veterans undergoing specialized treatment for PTSD. The therapeutic outcomes suggest these techniques are highly effective. The direct nightmare therapies described by the author consistently reduced the anxiety-producing features of nightmares and, in many instances, eliminated them altogether.

Introduction

In Sigmund Freud's earlier theories about dreams, the nightmare was an annomie, an obstacle to his development of a theory wherein dreams were wish fulfillments. However, as Freud's thoughts evolved about dreams, they became more inclusive about nightmares. In a later theory, according to Freud (1920), the traumatic nightmare represented a repetition compulsion. A person experiences a traumatic event which then repeatedly plagues the person in the form of recurrent nightmares. According to Krakow and Neidhardt (1992), reliving the event as a nightmare reproduces the anxiety from the traumatic event, and by reliving the anxiety, one attempts to integrate the trauma by repeating the experience over and over again.

Carl Jung's theories about dreams include the nightmare as a part of one's individuation, or ongoing development of the personality. Jung (1953) believed that within one's personal unconscious, related feelings, thoughts, perceptions, and memories "constellate" into a "complex." Nightmares arise from one's complex that contain the residue from some unresolved issue. Hall (1991) proposed that the nightmare functions as any other dream: to establish self-regulatory dynamics for the psyche known as compensation.

Both Freud and Jung seemed to have shared a common understanding that people frequently distressed by nightmares could be re-experiencing some stressful event from the past. Both perspectives on dreams suggest that therapy can provide relief from the dilemma of the nightmare experience.

Nightmares and PTSD

According to DSM-IV (1994) guidance, nightmares are one of several accompanying symptoms of post-traumatic stress disorder (PTSD). PTSD is a diagnostic term associated with the psychological response to events outside the range of usual human experience in which the person is a witness, victim, or participant. Examples of such traumatic events may include: a serious threat to one's life or physical well-being, the sudden destruction of one's home or community, or exposure to the catastrophic harrows of war. The characteristic symptoms of PTSD include: re-experiencing the traumatic event (as in a nightmare), avoidance of stimuli associated with the event, numbing of emotional responsiveness, and increased arousal.

This article explores nightmares and the treatment for them. The author is a staff member at...
the Northwest Post-Traumatic Stress Treatment Program, a Veterans Administration medical center at American Lake, Washington. This is a therapeutic milieu, adventure-based program that combines a variety of psychotherapeutic and psychoeducational components with an inpatient focus. The genesis of this article is the author’s experience in treating nightmares with a war veteran population in this clinical setting. A large segment of the three month program is devoted to rigorous trauma work. Dream therapy is an integral part of each client’s trauma treatment goals.

**Distinguishing Features**

Nightmares have certain shared characteristics that designate them as a distinct category of dreams. The nightmare is a frightening dream experience that usually awakens the person during REM (rapid eye movement) sleep. A nightmare may be a re-enactment of an actual experience, a total fantasy experience, or an actual event portrayed in combination with fantasy. Nightmares sometimes interweave multiple traumas into the same dream, and may include events that occurred several years apart. Peters (1990) noted that nightmares may even hijack ordinary dreams. In hijacking, a pleasant dream is suddenly disrupted and overshadowed by the presence of a nightmare.

As Calvin and Hartmann (1990) suggest, the person experiencing a nightmare almost always recalls a vivid dream of distinctly intense magnitude accompanied by an overwhelmingly fearful sequence, theme, or the combination of both. Nightmare sufferers frequently report other sensory information along with the visual experience, for example, smells, sounds, and even pain. There are often varied accompanying perceptions, that is, guilt, exhaustion, thirst, being doomed to die, and so on. The following dream sequence presents an example of a nightmare:

*It’s nighttime. I’m in a foxhole, shooting starts and there is a sudden blast of light and an explosion near me. I feel something strike my forehead. Blood flows into my eyes, I can’t see. I feel a searing pain. Now there is screaming near me, I feel helpless. I wake up.*

Readers may identify in this example several characteristics of a nightmare already described above. Noticeable in the example are the presence of varied sensory and perceptive phenomena. These elements combine to produce the dreadful and distressing experience commonly associated with the nightmare.

**Onset and Frequency**

Nightmares may start immediately following exposure to a traumatic event, or onset may be delayed for several years. Furthermore, it is not uncommon for trauma survivors to have the same identical nightmare year after year with little or no change in the way it is experienced. In treatment, some Vietnam veterans have presented recurring nightmares that were continuing to be re-experienced 20–25 years after onset. Amazingly, some World War II and Korean War veterans have reported experiencing the same recurring nightmare for ever longer durations.

Nightmares may be in complete remission during certain times of the year and quite active during other periods. A marked increase in nightmare activity may be more prominent around anniversary dates, especially where significant unresolved issues remain. A slight reminder or subtle hint from a current experience about past trauma is often enough to stimulate nightmare activity. Moreover, ongoing life adjustment or transition periods that create emotional tension in a person’s life may also activate nightmares. Although these points merit clinical consideration, Halliday (1987) reports there seems to be no consistently reliable predictor for the “fading” (diminished intensity or frequency) of a recurring nightmare over time other than nightmare related therapies. When implemented, direct nightmare therapies do become reliable predictors for whether a nightmare may fade or be eliminated.

Understanding the way that a recurring nightmare may wax and wane throughout a person’s life can be of paramount importance in treatment. The timing and rhythm of the nightmare experience should be explored relative to events in the person’s psychosocial history. This exploration should help establish the presence or absence of trends across time. The nightmare that recurs more frequently during a particular period of the year may reveal some very useful hints about its association to an unresolved event from the past.

**Shapeshifter**

In the movie, *Star Trek VI—The Undiscovered Country*, Captain Kirk and Dr. McCoy come face to face with a highly unusual lifeform from another galaxy known as the “shapeshifter.” In this
space adventure, the shapeshifter had the unique distinction of being able to instantly transform its physical appearance from one identity to another. The term “shapeshifter” may also be used to describe a similar phenomenon associated with nightmare activity (and ordinary dreams) wherein dream characters, objects, or figures actually transform identities or change into other things.

A shapeshifter in dreams may occur in various ways. A dream character may shapeshift between subsequent versions of a recurring nightmare where the dream has always been experienced in the same way. A shapeshift may also occur during the same dream sequence. Recognizable characters from an ongoing recurrent nightmare may even transform into a character known to the dreamer in real life. A dream character may shapeshift as a friend, foe, family member, or as the person dreaming the dream. The following dream sequence presents an example of this phenomenon:

I’m carrying the body of my recon team member, Tex, up the hillside on a trail. I lay him down. I look at him to find that Tex changes into my son. I hold him tight and begin to cry. I wake up. (Personal communication, 1993)

This sequence is from a recurrent nightmare shared by Sam, a marine combat veteran of Vietnam. He began to have the dream soon after his teenage son was gunned down as an innocent crime victim in 1989. The dream character, Tex, in real life was Sam’s fellow marine who was killed by sniper fire while on a mission. Notably, in this example, Tex’s shapeshift from combat marine to Sam’s son occurs within one dream sequence.

From a Jungian perspective, a possible significance of the spontaneous appearance of shape-shifts in a nightmare suggests at one level the client’s need to be more consciously aware of the way in which traumas have “constellated” into a “complex.” In this way, the shapeshifter tends to mark thresholds of possibility for the healing and transformation of whole complexes in the course of therapy.

Much is to be learned about shapeshifts and nightmares. There appears to be little information specifically about shapeshifting in dream literature. It is open to speculation as to whether shape-shifts are more common to nightmares than ordinary dreams. How frequently shapeshifts occur among nightmare dreamers is also unclear. The author’s work with war veterans being treated for chronic nightmares indicates that shapeshifts are fairly common experiences.

Strategy and Techniques

Nightmares present unique therapeutic challenges in treatment. Formulating clinical strategy and selection of techniques for treatment can be enhanced by awareness of the anxiety-producing features of a nightmare. In his overview of nightmare therapy, Halliday (1987) identified four anxiety-producing features common to the nightmare experience. These include: the nightmare’s uncontrollability, its perceived sense of reality, the dreadful and anxiety-producing storyline, and the nightmare’s believed sense of importance. As Halliday (1987) further notes, selection of strategies and techniques for treatment of nightmares ought to be based on their potential to extinguish the nightmare or diminish these distress producing features. Halliday suggests that any intervention that can affect relief from one or more of these factors should provide a margin of relief from nightmare distress.

A variety of direct nightmare treatment techniques exist that may be effectively applied to nightmare sufferers. Halliday (1987) grouped treatment techniques into four classes. These classes include: analytic and cathartic techniques, story-line alteration procedures, face-and-conquer approaches, and desensitization and related behavioral techniques. Direct nightmare interventions that combine compatible techniques from one or more of these classes may enhance overall treatment effectiveness.

Experience seems to indicate that, to be most effective, treatment strategies need to focus beyond the initial explanatory level of intervention. The following strategy has consistently produced encouraging clinical results and is suggested as an approach for treatment. This strategy has three successive levels of intervention and allows for integration of different techniques and approaches. The strategy includes: (1) initial discussions designed to help better understand the nightmare, provide a degree of relief from its distress, and identify contributing clinical issues; (2) intermediate interventions, that is, story-line alteration procedures, face-and-conquer approaches, and so on, that provide a further reduction of nightmare distress; and (3) follow-up therapy to engage and resolve identified clinical issues as needed. This three-tier, systematic approach to treatment not only employs analytic and cathartic techniques,
but also provides intermediate and follow-up interventions.

**Dream Group Approach**

A tradition in Jungian analytical psychology is the use of dreams in therapy. Jung (1953) wrote, "the dream is a little hidden door to the innermost recesses of the soul" (p. 53). He believed the dream portrayed in symbolic form the actual situation of the unconscious. The dream, according to Jung, has the value of a parable: it does not conceal, it teaches. Thus, when explored the dream enriches personal awareness. Jung’s illuminating ideas about personality and dreams includes such terms as persona, shadow, animus-anima, and Self and are used as a guiding approach in dream group discussions. Along with the integration of other dream work concepts, dream therapy unfolds from an essentially Jungian foundation.

The beginning point for each group is psycho-educational. Two initial sessions orient participants to Jungian theory and other dreamwork essentials. Examples include: dream recall techniques, guidelines for group dream therapy, direct nightmare treatment techniques, and introduction to sandplay. Clients are taught dream journaling and are encouraged to present troublesome nightmares for discussion during weekly dream group sessions. Group size is limited to 8–10 participants.

Each nightmare therapy group begins with an opening round. Each client makes a statement about “here and now” emotions and indicates if they have a dream to present. The group makes an agreement on whose nightmare will be discussed. Usually, one nightmare will be the focus of a session. Usually, one nightmare will be the focus of a session.

The dreamwork process unfolds with analytical and cathartic techniques (described in the next section) employed within a four-step process: (1) presentation of the dream by the client; (2) discussion of questions for clarification from group members related to the dream experience; (3) feedback from participants; and (4) formulation of an action plan by the client for points that need further disposition. This structure is based on the model described by Taylor (1992) in his book, *Where People Fly and Water Runs Uphill*. For the client, the final step of the process, the formulation of an action plan amplifies the achievements of that session and establishes milestones for continued therapeutic efforts. A closing round marks the end of each dream group and provides participants an opportunity to describe their personal experience and lessons learned.

**Analytic and Cathartic Techniques**

Analytic and cathartic techniques are efforts to enhance a client’s understanding of a nightmare within the context of their psychosocial history and life circumstances. These techniques allow appropriate expression of emotions and promote personal growth adjustments. Nightmare treatments in either individual or group sessions provide valuable arenas for analytic and cathartic implementations. The author’s experience suggests that for some clients group dreamwork may serve to be more advantageous than an individual session. A group can serve as a “safe haven” where clients feel encouraged to reveal frightening nightmares, share hidden dilemmas, and experience emotions in a supportive environment. Group members are also a valuable resource for analyzing and interpreting dreams.

Establishing parameters for how a dream will be discussed and interpreted can make the critical difference whether analytic techniques succeed in treatment. Clinical experience suggests that the most prudent method is to allow clients to be the interpreter of their own dreams. In group, members may offer feedback and observe what they believe the dream means, but in a prescribed manner. Following the Taylor (1992) approach, group members, when talking about someone else’s nightmare, are expected out of wisdom and politeness to prefix remarks with words to the effect that “if this were my dream,” and keep feedback in the first person at all times. In this way challenging and confrontative statements can be made in such a way that they may actually be heard and internalized by a client. The author’s experience in treatment indicates that such an approach seems to help clients feel safer, less defensive, and more willing to share their nightmares with others.

Having nightmares discussed in group or individual sessions can be therapeutic to the client. Feedback and observations from others can increase understanding of dream symbols, amplify the nightmare’s message, and assist with identification of related clinical issues. Although initial analytic discussions may produce a reduction in nightmare distress, without further intervention the issues that contribute to the life of the nightmare may not be resolved. Related clinical issues
that remain untreated, and unresolved, may continue to exist as contributing factors to the client's nightmare dilemma.

**Story-Line Alteration Procedures**

As described by Halliday (1987), these procedures are designed to change nightmares through rehearsing a new beginning, re-enactment of different endings, modifying some detail, or face and confrontation of adversarial characters or other feared nightmare objects. Story-line alterations procedures serve as catalysts that help diffuse and metabolize the energy of the nightmare and function to elicit new insights leading to core issues. Clinical methods known to aid such work include: sandplay, dream art, psychodrama, guided visualization, and hypnotic suggestion. The use of these procedures in treatment enable clients to alter the nightmare's distress producing features, and in some instances, may even eliminate a nightmare altogether.

Senoi dream techniques are used by the author as a working model to assist clients in creation and design of personal story-line alterations in nightmare treatment. These techniques, described in the work of Garfield (1974), originated among the Senoi people, a native tribe of Malaysia. Garfield's description of the Senoi dream system includes three general rules that are used as the basis for formulating story-line alteration procedures. The rules are: (1) confront and conquer dangers in dreams, (2) move towards pleasurable experiences in dreams, and (3) make your dream have a positive outcome and derive a creative product from it. Additional Senoi guidelines provide suggestions for altering dreams with a particular story-line or theme; for example, being chased or attacked. In the example that follows such a Senoi guideline is applied in a nightmare about falling.

Chris, a Vietnam combat veteran, survived two helicopter crashes while serving as a door gunner. More than twenty years later those experiences continued to haunt Chris in a fearful recurring nightmare about helplessly falling. Chris utilized the designated Senoi guidelines for falling in dreams: (1) rather than fall, attempt to fly, (2) whether flying or falling allow yourself to arrive at some interesting place, and (3) observe something useful or beautiful at that location. Chris imagined that he could soar like an eagle, his favorite bird. He allowed himself to fly to his favorite mountain retreat landing beneath a giant ponderosa pine. At this tranquil location, Chris choose to quietly sit facing the east and observe the beauty of the rising sun. (Personal communication, 1994)

This clinical example highlights the creation of a story-line alteration procedure modeled on Senoi dream techniques. The intervention was implemented through sandplay. The dream did not return during the course of a two year tracking period.

**Story-Title Conversion**

Story-title conversion is a simple cognitive procedure that helps clients encode new title-related cognitions and perceptions in treatment. Experience suggests that story-title conversion may enhance the effectiveness of other treatment interventions such as story-line alteration procedures and face-and-conquer approaches. The procedure effectively assists in the conversion of “ghost titles,” a term coined by the author that describes a subtle and often hidden phenomena among nightmare sufferers.

Ghost titles are self-defeating labels that function as the dreamers’ identifying index to a nightmare. Nightmare sufferers may unintentionally form such identifying titles especially for nightmares that have been recurring over long expansions of time. Such titles may consist of a few words or a single phrase, that is, “My Death Dream,” “Guilt and Punishment,” and “The Torture Nightmare.” Ghost titles reinforce the nightmare’s dreadful and anxiety-producing story-line and it’s believed sense of importance. Such titles may exist only in implied form unknown to anyone except the dreamer. Story-title conversion provides a way of changing the client’s ghost title into a more self-enhancing reference. Otherwise, a ghost title’s continued existence as a main cognitive index may impede other interventions designed to favorably change the nightmare. The following example illustrates how Bernard utilized story-title conversion concurrently with a story-line alteration procedure to treat a recurring nightmare.

I’m walking through a hallway. In the hallway are three red doors. I open them in succession. Behind each door are different images reminding me of a war zone trauma. I open the third door and suddenly awaken feeling horrified. (Personal communication, 1992)

The client’s story-line alteration consisted of modifying a single detail in the nightmare, a procedure suggested for any non-threatening dream element, for example, landscape, color, object, or figure, and so on. Bernard changed the color of the first door from red to blue. Blue was his favorite color which he associated with peace and tranquility. To Bernard his story-title conversion, “The Entrance to Peace and Tranquility,” had
special symbolic meaning, evoked pleasant thoughts and imagery, and expressed in a metaphor the story-line alteration of the dream. Bernard’s dream initially continued, but with reduced intensity and without the distressing images behind the doors. Three post-treatment episodes were experienced after which the nightmare discontinued altogether.

Face-and-Conquer Approaches

Halliday (1987) describes these approaches as methods designed to enable a client to face and confront feared characters, objects, or figures, while a nightmare is being experienced. Face-and-conquer approaches help increase feelings of control, alter the story-line, and reduce the distress features associated with the nightmare. Face-and-conquer approaches consist of instructions to a client to face and confront the nightmare threat as the experience is next encountered. These instructions often consist of scripted affirmations rehearsed in a ritual-like fashion in preparation for the feared encounter. As Calvin and Hartmann (1990) have noted, such affirmations may also assist clients in attaining a degree of lucidity (awareness during the dream itself that one is actually dreaming) during a nightmare experience. This lucid state of awareness permits a client to make choices to change a nightmare as it is being experienced.

Face-and-conquer instructions typically consist of a pre-sleep affirmation, a sleep affirmation used as awareness of the nightmare experience is realized, and a post-sleep statement that affirms and advertises client success. The following is an example of how face-and-conquer approaches may be employed in treatment.

Stan reported a disturbing recurrent nightmare during which he was faced by a threatening North Vietnamese officer dressed in a black uniform. Stan prepared for the nightmare encounter with this pre-sleep affirmation, “My dream is my creation and it doesn’t have to end in fear.” Stan reported that in the next nightmare encounter, he realized he was dreaming and said, “This is my dream and I choose to face it with courage.” Stan awoke the next morning feelingJoyed that he had met his dream adversary without fear and the nightmare encounter. The lucid state of awareness permitted the client to make choices to change the nightmare as it was being experienced. Halliday (1987) indicated that attaining lucidity during a face-and-conquer approach has particular importance because it helps to alter all four anxiety-producing features of a nightmare. According to Calvin and Hartmann (1990), with the attainment of lucidity the nightmare’s uncontrollability can be altered (because the client can choose actions in response to fear objects and/or scenarios). The nightmare’s perceived sense of reality is reshaped, the believed sense of importance can be modified (because dreamers realize they create and alter the nightmare) and the dreadful and anxiety-producing story line is changed.

Face-and-conquer approaches may be used concurrently with story-line alteration procedures. (Story-line alteration procedures include face-and-confront guidelines, not to be confused with face-and-conquer instructional approaches used by Stan in the proceeding example.) Face-and-confront guidelines are actions designed to alter a nightmare story-line. As described by Garfield (1974), Senoi-based face-and-confront guidelines instruct a dreamer being chased to stop and turn, face the aggressor, and subdue the adversary with either bargaining or aggressive action. Other dream allies or friends may be called upon for help. During the interaction, token gifts may be demanded of the aggressor. Token gifts are a mechanism designed to replace conflict with compromise and/or harmony. Token gifts ought to be beautiful and have symbolic value to the dreamer, for example, a tree, stone, flower, or poem, and so on. Token gifts may also be presented in return to an adversary by a dreamer.

Clinical observations seem to suggest, that when face-and-conquer instructional approaches have been used concurrently with face-and-confront story-line alteration procedures, reduced levels of nightmare distress were more apparent than when either intervention was used singularly.

Sandplay

Sandplay is an analytic and expressive form of therapy rooted in Jungian psychology. As Weinrib (1993) illustrates, the closest cultural parallel to sandplay is sandpainting, a Navajo spiritual practice that utilizes sand as a central element in healing ceremonies. In sandplay, unlike sandpainting, the client creates three-dimensional scenes in a tray of sand utilizing a selection of miniature, realistic characters, objects, and fig-
ures. According to Ammann (1991), Dora Kalff, a Swiss analyst, is credited with formulating most of the theoretical underpinning in orthodox sandplay. Jung (1953) was involved in sandplay as part of personal individuation efforts. A description of Jung's experience with sandplay is found in his chapter on "Confrontations with the Unconscious," in *Memories, Dreams and Reflections*. Jung's writings suggest that the symbolism of dreams and sandplay are similar in that both represent a practical confrontation with the unconscious. The symbolic world of sandplay makes it very compatible with dream therapy. When utilized in concert with dream study, sandplay represents a formidable therapeutic compliment to the process.

Sandplay seems to be receiving more attention in recent years by some practitioners as a legitimate medium for working with dreams. Hall (1991), a Jungian analyst, described sandplay as a projective medium that can be extended to dream therapy. Hall (1991) writes, "sandplay offers a quick and effective way to make rapid objectification of unconscious images from dreams or to continue the action of a dream and develop it further" (p. 334). Hall also noted that, "sandplay pictures can be interpreted with the same principles that are used for dreams" (p. 333). Patterned on ideas similar to Hall's (1991), the author employs sandplay as a projective medium through which nightmares can be re-enacted, story-line alteration procedures staged, and face-and-conquer approaches rehearsed. Clients have the option of dreamwork with or without the aid of sandplay.

Sandplay creations are always constructed in individual sessions. As described by Hall (1991) the therapist observes and encourages the client, recording the order in which objects are chosen, makes notes, and listens to the story shared by the client about the sandplay are creation. Two polaroid pictures are taken. One for the client to retain and one for clinical records.

Clients often share their sandplay creations in nightmare therapy groups as a follow-up to individual sessions. This allows more opportunities for feedback and enriches the analytic cathartic process in exploring the symbolic and possible meanings of the nightmare. Dan provides the following description of his sandplay experience:

> "In my nightmare I am being pursued by an evil figure that usually has the form of an NVA (North Vietnamese Army) soldier. I first discussed the dream in group which helped reveal several valuable messages. After group, I went to the sand tray to work out a solution to the recurring nightmare that I had endured for the past twenty-five years. I re-enacted my nightmare in the sand tray using symbols to create the scene. After setting the scene I used Senoi techniques to make changes in the nightmare. In the sand tray I turned and confronted the evil pursuer and asked him for a gift. I then presented him a gift in return. I did not have the same recurrent nightmare again though I did experience two different nightmares with a theme of being pursued. For both of these I was able to turn and confront the pursuer in the dream without fear, dread, or awakening. I received a lot of relief with sandplay." (Personal Communication, 1994)

In her book, "Images of the Self," Estelle Weinrib (1983) writes, "at its best, sandplay is a prime facilitator of the individuation process. At its least, it is an invaluable adjunctive modality" (p. 88). As Dan's case demonstrates, sandplay's therapeutic attributes make it an invaluable tool for nightmare treatment. Clinical trials have been encouraging and suggest there are advantages for its use in direct nightmare therapies.

**Survey Discussion**

A survey was administered to ascertain the effectiveness of several treatment techniques described in this article. Post-treatment reports were gathered by way of semi-structured interviews with 25 randomly selected clients within a one year period following completion of treatment. Data was gathered from clients who: (1) worked on a minimum of one recurring nightmare in which the analytic cathartic group approach was used; (2) engaged in individual follow-up with sandplay for a story-line alteration based on Senoi dream techniques; (3) completed a story-title conversion; and (4) participated in some form of follow-up therapy to address related issues identified during the dreamwork process.

Successful treatment outcomes were measured by elimination of a nightmare or reduction of nightmare distress. Based on survey results, 65% of the respondents reported their nightmares were eliminated. The other 35% reported continuing episodes with their nightmares but with diminished distress-producing features associated with the experience. The descriptive results from this latter subgroup indicated that: (1) nightmares were less frequent and more controllable; (2) nightmare story-lines were altered in a way that provoked less fear; and (3) the sense of reality and believed sense of importance associated with their nightmares had decreased.

Although limited as this survey was, the results are positive and seem to legitimize the effective-
ness of these treatment methods. The survey also beckons for more formal research to be conducted in this area. Many of these techniques need separate study. For example, sandplay’s potential in nightmare treatment merits closer examination. The use of face-and-conquer approaches, not included in this survey, could be studied as part of a sandplay intervention. And finally, research for story-title conversion may yield new ideas for employing such a technique in direct nightmare treatment.

Summary

Recurrent traumatic nightmares are a hallmark symptom of PTSD and may often be attributed to some catastrophic event from the past. It is critically important that trauma survivors in treatment for PTSD be presented the opportunity to explore the imagery and symbolism conveyed in a nightmare as a potential avenue to personal growth and adjustment. Accordingly, this article describes a number of concepts, techniques, and approaches that may be employed with a range of trauma survivor populations in different treatment settings. The ideas offered herein not only offer a measure of hope for nightmare sufferers but also demonstrate that creativity and innovation can give rise to very effective designs for nightmare therapies.

References
