Posttraumatic Nightmares of Traumatized Refugees: Dream Work Integrating Cultural Values

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This study examines the mental health function of dreams and dream work in integrative psychotherapy with 2 refugee women. The clients were from West Africa and the Middle East, and both suffered from posttraumatic stress disorder (PTSD) and repetitive nightmares. In a culturally sensitive integrative psychotherapy dreams were interpreted with respect for cultural meanings. The dream work initiated a mutual exploration of the dream images and led to an insightful processing of traumatic experiences.

Keywords: cultural aspects, dream work, psychotherapy, PTSD, rituals

Nightmares are a typical feature of PTSD, and they present as an enduring problem after otherwise successful PTSD-treatment (Belleville, Guay, & Marchand, 2011). Dreams have nonetheless provided a source for healing, both in Western psychotherapeutic settings and among indigenous people in other cultures. While Western psychotherapists from various theoretical schools use dream work with clients occasionally (Schredl, Bohusch, Kahl, Mader, & Somesan, 2000), dreams exert a strong influence on life in many other cultures. In many African cultures they are viewed as a form of communication with ancestors or God(s) and they contain guidance or instructions for the dreamer in times of crisis (Maiello, 1999; Schreuder, Igreja, van Dijk, & Kleijn, 2001), whereas in Middle Eastern cultures dreams are used to make important life decisions (Edgar, 2004, 2011). Despite the significance of dreams across cultures in mental healing efforts, little research is available of dreams as a psychotherapeutic tool with traumatized refugees. Culturally sensitive treatment guidelines highlight the need to pay attention to clients' cultural beliefs and values (Kirmayer, Guzder, & Rousseau, 2014; Whaley & Davis, 2007), and ignoring cultural meanings can impede a successful outcome. Because of their universal occurrence and the significance they comprise in numerous cultures and subcultures (Krippner, Bogzaran, & de Carvalho, 2002), dreams may serve an adaptable means of working through traumatic experiences with culturally diverse clients. The present study examines the efficiency of

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dream work with nightmares in psychotherapy with two traumatized refugee clients, from the Middle Eastern and African cultures.

Nightmares and PTSD

The majority of people across cultures experience disturbing dreams and nightmares after trauma exposure (Hinton & Lewis-Fernández, 2011). In some cultural groups nightmares may evolve into the most influential symptom after trauma (Hinton, Hinton, Pich, Loeum, & Pollack, 2009), tormenting the victim years or decades later (Guerrero & Crocq, 1994; American Academy of Sleep Medicine, 2005), even after otherwise successful standard PTSD treatment (Belleville et al., 2011; Spoormaker & Montgomery, 2008). Studies vary in the definition of posttraumatic nightmares, ranging from frightening elements that the dreamer associates with the trauma to replicative dreams comprising precise fragments of the terrifying event (Phelps, Forbes, & Creamer, 2008). Associations have been found between nightmares and significant sleep loss (Germain, 2013; Woodward et al., 2000), nocturnal awakenings (Germain & Nielsen, 2003), daytime distress, and impaired functioning (Levin & Nielsen, 2007; Wittmann, Schredl, & Kramer, 2007; Zadra & Donderi, 2000). Because of the substantial impact on the well-being of the dreamer nightmares should therefore deserve more attention in psychotherapeutic interventions targeted at treating sequelae of traumatization.

Dreams are not simple replications of memories (Fosse, Fosse, Hobson, & Stickgold, 2003), but contain among fictitious content selective personal experiences, as though original memories had been reduced to more simple units (Malinowski & Horton, 2014). Hartmann emphasizes in his theory of the function of dreams the strong connective quality of memory particles, new and old, creating a pivotal central dream image in the process (Hartmann, 1984). The emotional life of the previous day seems to have a guiding role in the selection of the events and experiences appearing in dreams of the following night (Hartmann, 1996, 2010; Kramer, 1993). Research by Kramer (1993) and Cartwright and colleagues confirms that dreams play a part in the active processing of emotional experiences (Cartwright, Agargun, Kirkby, & Friedman, 2006; Cartwright, Luten, Young, Mercer, & Bears, 1998). It seems that especially the suppression of unwanted thoughts before sleep may lead to an increased appearance of these thoughts in dreams of disturbing quality, as a recent study with 30 health participants showed (Kröner-Borowik, et al., 2013).

Hartmann (1984) describes temporarily distinguishable phases in the dreams of trauma victims: Immediately after trauma dreams contain the event itself, which during the next phase evolves into a dream containing a central image evoking strong emotions of terror or fear. Then, dreams contextualize guilt or shame, and still later, they contain grief or sorrow. Dreams after this phase contain no links to the terror associated with the traumatic event (Hartmann, 1998). Barrett (1996), as well as Terr in a sample of child trauma survivors (Terr, 1991), have observed a naturally occurring change with time, of frightening dream content early after trauma into dreams richer with memory particles, symbols and cultural meaning (Barrett, 1996). In another study, Wilmer observed in 107 Vietnam veterans recovering from posttraumatic stress in psychotherapy their gradual move through

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three types of dreams (Wilmer, 1986). Coalson (1995) studied the treatment outcome of traumatized combat veteran clients who had worked on a minimum of one recurring nightmare in therapy. The results of a posttreatment survey showed that 65% of the clients reported a total elimination of the nightmare and 35% reported diminishment of distress-producing features in the nightmare (Coalson, 1995).

Only recently the mood regulator role of dreams has gotten positive affirmation through neuroimagining studies (Levin & Nielsen, 2007; Walker & van der Helm, 2009), made possible through the improvement of measuring techniques. Researchers trying to refute a mental health function of dreaming, have until lately seen its importance only on a neurophysiological level and not on an experiential level, where the content of the dream would play a major role (Hobson & McCarley, 1977; Hobson, 2002). However, in his recent protoconsciousness theory Hobson proposes a functional use of dreams via provision of a virtual reality model of the world, through which waking consciousness can be developed and maintained (Hobson, 2009; see also Solms, 2013).

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Dream Work in Psychotherapy

Trauma victims seem to prefer working with dreams to more direct therapeutic approaches because they perceive dream material as less threatening than the waking life experiences they might illustrate (Cohen, 1999). Models of working with dreams have been developed since the beginnings of psychotherapy more than one hundred years ago, and troubling dreams and recurrent nightmares are still seen as one of the strongest indicators for dream work by psychoanalytic (Hill, Liu, Spangler, Sim, & Schottenbauer, 2008) and cognitive psychotherapists (Freeman & White, 2004). In psychodynamic therapies the interest has shifted from the emphasis on hidden or latent content of dreams (Freud, 1900) to the manifest or directly observable content and their interpretation, which is explored in a mutual attempt by the psychotherapist and the client (Blechner, 2013; Caperton, 2012; Fosshage, 1997). The capacity of the manifest content of dreams to provide information on relationship patterns and current life issues of the client is today comprehended in an equivalent manner across diverse therapy schools: modern psychodynamic, existential/Gestalt-, cognitive–behavioral, and cognitive–experiential therapies (Eudell-Simmons & Hilsenroth, 2007). Further, all of these diverse therapies acknowledge an integrative function of dreaming, and the emotional and cognitive aspects dreaming comprises. They emphasize the potential of dreams as illustrations of personal conflicts and salient issues in the waking life of the clients and the affective responses to these themes, contributing to insight, awareness, and understanding. Other integrative models of dream work, combining psychoanalytic as well as cognitive–behavioral and experiential techniques, provide more detailed rules of procedure (Cougar, 2004; Freeman & White, 2004; Hill, 2004; Hill & Knox, 2010).

In his experiential approach to psychotherapy Gendlin (1986) introduced the technique of Focusing into dream work, where attention is drawn to the relationship between therapist and client, bodily awareness, and the emotions felt during the dream. Through open-ended questions the therapist leads the client to discover new ways of relating to him or herself. Different elements of the dream are

examined through associations, elements of drama, working with characters, decoding the dream information, and dimensions of development. These categories can be covered in whole or in part, depending on the individual therapy process. Elements of Focusing-oriented dream work can be easily integrated into diverse therapeutic approaches (Leijssen, 2004).

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Cultural Aspects of Dreaming as a Curing Practice

Traumatic events and their aftermath are processed within traditional, locally and historically embedded belief systems. Dreams and nightmares after trauma are interpreted via a filter of cultural traditions, which together with personal values attached to dream content have a vital effect on the self-esteem and well-being of the dreamer. Hinton and colleagues (2009), investigating nightmares of Cambodian refugees, point out the capacity of the nightmare to function as an illustration of the dreamers' experience of the trauma, depicting key aspects of the traumatized individual's identity.

Many traditional African and Asian cultures and indigenous societies view dreams—contrary to modern Western beliefs—not as internally generated or featuring a window presenting knowledge about the dreamers′ inner subjective world (Holy, 1992). They may instead appear as a channel of communication with another world, for example, the world of the dead or a ghost world (Desjarlais, 1991; Shore, Orton, & Manson, 2008). In a number of African cultures ancestors appearing in dreams are connected to madness, spirit possession or death (Englund, 1998). Dreams are also used in curing practices (Patel, Simbine, Soares, Weiss, & Wheeler, 2007; Schreuder et al., 2001) and trauma victims hunted by nightmares may perform specific rituals and practices in an effort to protect themselves, or they try seeking help from a cultural healer. This healer, diviner, or shaman either gets instructions for healing in his own dreams, or he interprets the dreams of his clients (Adekson, 2003; Buhrmann, 1984; Crawford & Lipsedge, 2004; Krippner et al., 2002; Laughlin & Rock, 2014).

Sometimes traditional belief systems can contribute to psychological distress and complicate aspects of traumatic stress. Conventional African wisdom as understood by clients coming into therapy can work counterproductively in relation to Western-based intervention principles when not respected and—when necessary—included (Eagle, 2005; Englund, 1998). One study from South Africa exemplifies this in describing the integration of dream work with indigenous healing in the case of a woman who could not grieve appropriately the traumatizing murder of her son. In psychotherapy she narrated a dream, which she interpreted as a message to her that her son's spirit was not at rest and she should perform cleansing rituals. In agreement with her therapist she consulted a traditional healer who gave her instructions for the performance of a ritual. The therapist noted that after the ritual the clients' work became notably more focused and fluid (Eagle, 1998).

Studies portraying Iranian culture depict the high significance of dreams in personal and even political matters (Edgar, 2011), which can be found in other areas of the Middle East as well (Mittermaier, 2010). The interpretation of dreams is an accepted and popular custom and even a recognized skill of the clergy. It is believed that dreams can inter alia warn of danger or convey a cure to a medical

condition and certain dream images are traditionally interpreted in a strongly negative manner. Although Iran is traditionally a patriarchal society, the women influence significant decisions in the home, and the majority of women rely on dream interpretation concerning these decisions (Rahimian, 2009).

The number of traumatized refugees settling in Western countries is rising at a fast pace and psychological treatment for this group of mental health clients is considered complex and demanding, with a high number of drop-out rates (Nickerson, Bryant, Silove, & Steel, 2011; Ter Heide & Smid, 2015). Studies are needed to identify elements of psychotherapy that are universally effective. Embracing the information gathered from the above research studies, dream work appears a feasible tool in psychotherapy with individuals who come from cultures, where dreams are appointed a significant role in times of distress. Especially traumatized refugees experience a high occurrence of nightmares (Hinton et al., 2009) and case studies of psychotherapeutic work targeting especially nightmare reduction could add valuable information and help improve and develop PTSD intervention methods. Traumatized refugees are in most cases entering psychotherapy with a professional from another cultural background. Cultural preconceptions about the therapist and psychotherapeutic work may hinder the client to bring the content of his nightmares to psychotherapy sessions, and it may as well hinder the psychotherapist to ask for dreams to use as material in psychotherapy (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001).

The aims of the present study are, first, to describe dream work as a therapeutic tool in psychotherapy with two traumatized refugee clients. The second aim is to examine ways how dream material reflects therapeutic change in the recovery from trauma-related distress, meaning changes in processing traumatic memories and changes in levels of PTSD-symptoms and well-being.

Method

Two women participated in individual psychotherapy, where dream work evolved and formed a significant part of the therapeutic process. The first author (C.S.) of the present study was the psychotherapist in both cases, and the therapy context was an outpatient clinic for the treatment of mental health problems of refugees. The clients were refugees from West Africa and the Middle East, both with a history of interpersonal trauma and experiencing PTSD at the start of therapy. The participation in the study was voluntary, the clients were informed about the study details and asked permission to record the sessions on tape, and they gave written consent. In sessions when recording was because of technical problems not possible, the written notes done by the therapist directly after the session were used. Anonymity was guaranteed and name and other identifying information are omitted or details changed. Pseudonymes are used for the purpose of reporting the results.

The approach in the psychotherapies of the present study was integrative and culturally sensitive, maintaining a psychodynamic focus with additional use of cognitive–behavioral techniques when deemed necessary. An emphasis was put on flexibility and adjustment to respond to the individual needs of each client, who both were refugee women with a trauma history. The sessions took place once a

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week and were recorded on audiotape. In sessions where recording was out of technical problems not possible the written notes by the therapist were used.

Measures

PTSD-symptoms were measured with the Impact of Event Scale–Revised (IES-R; Weiss & Marmar, 1997), a self-report measure consisting of 22 items. The items cover intrusion, avoidance, and hyperarousal experienced during the past week. Each item is rated for the distress experienced during the past week by the client on a 0 (*not at all*) to 4 (*extremely*) Likert scale and the total score ranges between 0 (no symptoms) and 88 with a cut off-score of 34. The IES-R has been found reliable and valid among refugees (Morina, Ehring, & Priebe, 2013). The scale was administered twice, once at the beginning and once at a later point of the psychotherapy process.

Results

Case Report 1: Luisa

"Luisa"[1] is a West African woman, who started psychotherapy with the first author of the present study when she was 33 years old. She had come to live in Finland as a refugee from a war affected area two years before. She had lost both her parents and siblings 9 years earlier in a military attack on her home village. She had to flee her home country and lived almost 7 years at a refugee camp on the African continent before coming to Finland as a legal refugee. During assessment Luisa presented with a range of posttraumatic symptoms. She complained about various pains and a difficulty falling asleep and staying asleep. In addition, Luisa was constantly nervous and worried about her life and the life of other people she knew. For many years she had problems associated with eating that resulted in a considerably low bodyweight. Luisa was further concerned about her health in general, which she described as poor. At the start of therapy her score on the measure for trauma symptoms the IES-R, was 57.

Treatment. After the assessment phase Luisa started psychotherapy with sessions once a week. Luisa came to the first two sessions with an air of formality and reserve. In the second session she cautiously revealed her doubts about therapy in general: how could talking to a stranger about the difficult times in her past life could help her to get better? Her therapist offered her to answer questions she had about the therapy process and procedures. Luisa admitted a strong reluctance to share details about the traumatic events that had happened before her flight from her home country. After hearing from her therapist that they could focus on things Luisa wanted to talk about, Luisa seemed relieved and proposed as the most important goal of her therapy to get better again.

In the following sessions Luisa slowly started to share particulars from her new life: her financial difficulties, and the challenges in learning the language and

[1] The client's name and details of her family have been changed to protect her identity.

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building a social network. She also complained about ongoing physical pains in her body, the frequent visits to the doctor, and her difficulties of getting sleep. In the sixth session Luisa revealed that she had started drinking alcohol in the evenings to sooth her nerves after leaving the refugee camp. She had no knowledge of the health risks linked to alcohol, when informed of them by her therapist who suggested that she could write down the amount of drinks each night to illustrate the extent of the problem. In the eighth session, Luisa admitted she was feeling ashamed because of her drinking habit and she worried what her therapist might think of her. She could not monitor her drinking because writing it down made it more real and more shameful. Luisa thought her therapist would disapprove of her behavior because she had pointed out the health risks of it. Maybe there was a reason for her drinking, the therapist replied, and Luisa looked relieved. She drank because it made her forget, she said, but during the night the bad thoughts would still come back and harass her mind.

In Session 13 Luisa complained about nightmares. After the attack and during the first years at the refugee camp she had suffered badly from terrible nightmares, which had decreased with time and stopped upon arrival in Finland. Now they disturbed her again. She thought psychotherapy was the cause for them. She wanted to end the therapy. Luisa did not feel comfortable sharing the dream content, and she thought people in Finland did not value dreams. Her therapist told her that dreams of patients are considered very useful in psychotherapy. Then she asked her how she would deal with this kind of dream in her home country. Luisa explained the need of going to a traditional healer who could understand the meaning of the dream and tell the dreamer, what to do. Luisa added that she could not do this now because she did not know anybody in her new home country with this kind of powers. The therapist encouraged Luisa to share the content of the nightmare with her instead. Finally, Luisa described the content of a nightmare that had started to occur again almost every night:

Peanut dream. *M: . . . I always dream I am among dead people. I dreamt about this man, he was a big man in our town. He, he died many years ago, even before my family died. They killed him during the war. So, I dreamt about him, I saw him together with his son. I do not know if the son is alive but I do know that the father is dead. I was walking through his farm. They were harvesting peanuts. They did not wear any T-shirts, only trousers. Suddenly I saw peanuts on the floor and I started picking them up in my hem. Then the man who is dead came and asked me what I was doing. I said I am not stealing your peanuts. I just picked those lying on the floor. He said let me get you some. . . . When I turned on my right, I saw only swamp, when I turned to the left, swamp. I thought were could I go? There is nowhere to go. The man came back with the peanuts but I just thought no place to put the peanuts, no place to go. Then I woke up horrified.*

As Luisa started talking about the content of the nightmare her anxiousness rouse considerably and she began fidgeting nervously on her seat. She was terrified of the dead man appearing alive in her dreams because she thought that it was a sign from the world of her ancestors. Maybe it was she had done something bad? This was usually the case when ancestors disturbed dreams. But, she added, she had not done anything wrong in real life; she had never stolen any peanuts from this

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man. Her therapist pointed out that the man thought it ok for her to have some peanuts. Luisa agreed to this and calmed down. During the session Luisa did not bring up the traditional healer anymore.

In Session 14 and 15 the therapist and Luisa discussed the dream repeatedly. Luisa explored details of the dream in a more relaxed state. In Session 14 she said she had not stolen the peanuts, but she still felt guilty. She pondered about some specifics in the narrative, the people she had seen in the dream, the places she had visited, and their counterparts in real life. Luisa admitted to believe that the same ancestors who disturbed her sleep were also inducing the pains she felt in her body. Luisa and her therapist started discussing cultural norms and values, which led to a conclusion that dreams can have a cultural meaning, constructed to maintain social control and norms, and a personal meaning, which can be of value for the dreamer. In Session 15 she said that it was difficult to be confronted in dreams with people from her homeland. During daytime she did not want to think about them and her life back there and tried to suppress these thoughts. She went silent for a moment and then concluded that this suppression had not functioned during sleep.

In the fourth session after narrating the peanut-dream, Luisa felt guilty and ashamed of her conduct toward her dead relatives. In the turmoil of the attacks she had lost them and had no knowledge of what had happened to the others, she just had tried to flee and stay alive. After her flight she stayed for some months at a town near the border, where she got news from a villager that her mother, her father, and her siblings had died. Discussing the dream with her therapist she experienced relief, and she began bringing more dream material to the following sessions (Session 16–18). Another dream contained dead people.

Dream of the dead neighbors. *M: I went to my hometown. . . . Then I went to this one lady who was my neighbor, she is dead now for many years. So I thought let me go there and greet her grandchildren. And I went in the house and I saw two children there. I know one of them is dead. I wanted to ask him in the dream why he is there playing even when he is dead but my mouth was heavy, I could not utter a word. I asked only where is your sister? They said that she is out playing. Then I saw a child, a little boy in the bed. I asked who this was. The dead boy answered that this is our brother. He is dead, he said. I went to the bed and looked at him and I saw he also was dead. Then, taking a closer look, I saw there were four persons in the bed, all dead! I asked, all these people, they are dead? The boy said yes. Then I recognized one dead girl as a girl I know and I asked: even she is dead? The boy nodded. I started going back, taking some steps in reverse and then I woke up shouting.*

Luisa knew that some of those people in this dream were dead, but she was not sure about the fate of the others. After the dream she remembered waking up in panic and lying awake full of worry. Her therapist encouraged her to take an explorative stance toward the emotions she felt during and after the dream. Luisa said she blamed herself for not being able to help the people who had died during the attack. After opening up about her feelings she started to cry. When she stopped crying, Luisa shared details she remembered from the attack. She remembered also seeing dead bodies. In the twentieth therapy session the fact that she had survived as the only one of her immediate family rose to the foreground, again through the narration of another nightmare she had seen.

Escape dream. *M: I was walking in darkness, in the night with a woman I know. It seems I was near my hometown somewhere. Suddenly I heard steps behind*

us and we saw there was a man coming after us. We started running, running, and we came to a village and started hitting on the doors and screamed there is a man coming after us, he will kill us! The doors did not open and I went to another and started hitting again and I saw this man behind me. He wanted to grab my hand and, as soon as he grabbed me, I felt like a shock going through my body. Then one door opened and a person signaled me to come in, and I just entered, but this man entered too! But the person that had signaled me to enter just closed the door. I had been so anxious to get away (from the man who went after us).

Exploring this dream, Luisa said that the man who followed her stood for the bad things that just do not go away by themselves. She was ashamed of herself because she had not arranged a traditional funeral ceremony after her relatives had died. The ceremony had to be celebrated together with other mourners and it included among other steps the preparation of special ingredients. The therapist asked her whether these ingredients were available also in her new home country, to which Luisa nodded. The therapist then suggested asking a friend to conduct this ritual together. Luisa's face lit up. She knew a friend who certainly would agree helping her. At the end of the session Luisa seemed relieved.

In the fifth session the funeral ritual had been done with the help of Luisa's friend. Luisa told her therapist how they had done the ritual. She added that she had not seen the same kind of dream anymore. She felt much better. The therapy lasted for 30 sessions, and during the remainder of time Luisa did not see these nightmares anymore. At the end of therapy she felt better in general, ate regularly, and felt less nervous during the day. Her PTSD symptom score on the IES-R 39 had changed from 57 to 39 points and was considerably lower than at the beginning of treatment. Half a year after the end of the therapy, the psychotherapist received a phone call by Luisa. She was studying and did not worry as much about daily life than she had done before. She still experienced sleeping problems and disturbing dreams, but they troubled her less. Her eating problems were smaller and she had started a relationship with a man.

Therapeutic strategies used. Psychodynamic elements mainly used were working on accessing and reviewing unpleasant emotions, and the identification of patterns in the patients' actions, experiences, thoughts, and feelings. Management of cultural transference and countertransference in addition to personal transference was applied. Cognitive–behavioral elements were education about the disorder, homework assignments, monitoring of dysfunctional activities and the support of adaptive coping skills, and altering attributions of meaning. The identification of therapeutic aims at the beginning of therapy was important and supported in the client a feeling of being in control. A nonjudgmental and respectful attitude toward the client's cultural worldview of and the cultural conceptualizations of health, ill-health, and treatment were central throughout treatment. In dream work, elements of Focusing technique were used (Gendlin, 1986).

Case Report 2: Shirin

Shirin[2] is a refugee woman from a Middle Eastern country. At the time she started psychotherapy with the first author of the present study Shirin was 41 years

[2] The client's name and details of her family have been changed to protect her identity.

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old and had been living in Finland for almost seven years. She had been diagnosed of PTSD in a psychiatric clinic some time after her arrival as a refugee in Finland and had been in psychotherapy in the outpatient clinic for the treatment of psychiatric disorders of refugees, which had lasted two and a half years. Shirin had been arrested in her home country "out of the blue" for political reasons in her home country and had been held in prison for several months while she was constantly tortured. During the first treatment Shirin had not opened up about the nightmares she experienced almost every night. Two years and two months after this first therapy had ended, Shirin asked for the possibility to start psychotherapy again with the same psychotherapist (C.S.) as before. She started therapy one month later. At the time of entering this second psychotherapy, she still experienced anxiety, a phobia of high places, and heavy pains in her back that were considered psychosomatic after clinical examination. During the initial assessment phase of the second psychotherapy these symptoms were interpreted as an expression of PTSD symptomatology.

Description of the presenting problem. At the time of the assessment phase Shirin suffered from sleeping problems and nightmares. She desperately wanted to move into an apartment on a lower floor because of her fear of heights. Her constant back pains made her fear of having a deadly disease. She felt miserable and had fantasies about her own death, which alternated with a fear of dying and leaving her children without a mother to care for them. She still found it very difficult to discuss any details related to her torture trauma and as her main targets in therapy she put being able to be a better mother to her children and to reach a more quiet state of mind. Her score on the IES-R was 73 at the start of psychotherapy.

Shirin wanted help to get over her torture trauma, but until Session 43 she avoided talking about it. She complained about the difficulties she encountered living as a refugee and single mother in a foreign country and barely speaking the official languages in use. She criticized herself in her role as mother to her children and described being constantly nervous and short tempered. Her therapist worked with her on identifying maladaptive beliefs and developing parental coping skills. She seemed to be in a very cooperative mood, but between Session 5 and 19 she canceled six times because of either her or a child's illness. On returning to therapy after two consecutive missed appointments in Session 20, Shirin complained that she did not get concrete help from her psychotherapist. In Sessions 21 to 34 the focus was on helping Shirin to cope better with her pain, first through monitoring her pain and her daily activities and second through scheduling them and changing some details in the ways she used to do household chores. Between Session 35 and 37 Shirin moved with her children to live in an apartment on the second floor of an apartment building, which helped decrease her fear of high places.

In Session 43, having displayed slightly more positive feelings in the last sessions, Shirin mentioned her torture trauma directly and drew a connection between her pains and the torture she had endured. She cried a little. In the following session she complained that the therapy did not help her, because it made her remember the sad things that had happened to her, sometimes even in her dreams. Her therapist asked her about the content of the dreams but Shirin went on to talk about her oncoming doctor's appointment. She then cancelled the next two sessions because of a flu. In the following session her therapist confronted her

regarding her frequent absences and asked her whether it sometimes felt difficult to attend the sessions. Shirin admitted that she was still terrified of having to return to her personal torture trauma, which her therapist met with empathy. In Session 47 and 48 the therapist tried to strengthen Shirin's internal resources and lead her attention to the part of her that actively tried to do something to alleviate her problems.

To Session 49 Shirin came looking wrought up and tired. She had experienced a very upsetting nightmare and she had been too afraid to fall asleep again. Shirin thought there was no use in telling it, because she was well aware of the meaning of this kind of dream in her culture: she was to die soon. The therapist asked whether there were any signs in real life that would confirm her belief. "No," Shirin answered. Still, she could not get around to trust that her life would continue for more than a few months. Her therapist mentioned the pains Shirin often complained about and she began to weep again. She could not call her mother on the phone because she could not keep the dream a secret and the old woman would be terrified of her daughter dying. The therapist suggested to her to examine the dream together and finally Shirin consented.

Uncle dream. *S: I was at home, at my parents home. Then, my uncle came and took me by the hand. I was startled because I knew he was dead. He did not say anything but held my hand in his and smiled at me. I was horrified and he started to hold me stronger. He was leading me away from my home. I screamed loud but nobody came to help me. He just kept pulling my hand.*

According to her cultural tradition seeing relatives or friends, who are dead in real life alive in a dream meant that the dreamer would also die soon. Shirin was horrified. Returning to the dream in the next session, Shirin said she had never experienced this kind of emotion but in her darkest hours in prison. Her therapist commented that trying to avoid memories of terrible times is understandable because of the pain connected to it. But maybe the dream is acting as a signal something? Her therapist led her attention to her body: did the dream activate any sensations in her body? After a little pause Shirin nodded. She felt her whole body to be in a state of shock. She then started to describe a situation where she had felt alike: it was when the men came to arrest her in her home. In her memory she was like going mad with fear of the things to come, and in the dream she felt a similar sensation.

Shirin feared for her life, but at the same time she had admitted in earlier therapy sessions that she was tired of going on with it and even wanted to die. She desperately wanted to forget the traumatic events and concentrate on the present with her children. In her earlier therapy it had been impossible for her to return to the torture trauma in her conscious mind. She was still afraid to open this Pandora's box. The therapist asked whether Shirin could think about the dream again. Could there be any other meaning or messages that this dream had for her? The therapist added that dreams can sometimes have personal meanings beyond cultural ones, which are tied to the persons own life and experiences. Between Session 52 and Session 53 a second dream occurred.

Hometown dream. *S: I was in my hometown again. I went out in the street with my mother. Suddenly I saw somebody coming my way, it was a neighbor and I knew*

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she was dead in real life. She came nearer and smiled at me. When she opened her arms as if she wanted to take me into her arms and take me with her, I woke up in horror.

Again, there was a dead person in the dream who wanted to take her away. This time she was not alone but with her mother, and during Session 53 she commented being somehow angry at her. In the dream it was as if she just gave Shirin away to death. This was completely odd; her mother always tried to help, and the death of Shirin would be the worst that could happen to her mother. In Session 54, Shirin revealed for the first time how she had been fetched by the secret police. She was arrested because her husband, a high rank military official, had been suspected of spying. Her parents originally had introduced her to him, and her mother had thought highly of this man. Suddenly she said that in prison she had felt the sensation of dying and was sure of never seeing her family again. Maybe the shame she had developed later— back in freedom—for the experiences in prison, had led her to believe it a better solution to be dead than living. She had not understood until that moment how much her shame of the dreadful events she had survived influenced her wellbeing negatively. It was as if she had not allowed herself to get better. The fact that she fled the country, leaving her husband, who she suspected of being still in prison, behind, added a guilty feeling because her children lived without a father now. In Session 55 Shirin wanted to start writing down the traumatic events. For her children, she added. She felt more energetic and the pain had decreased. In Session 56 she had reduced the amount of painkillers she had used until then, by half.

Shirin saw a third dream before session 63.

Dog dream. *S: I was in my parents' garden though it looked somehow bigger. A huge dog was suddenly coming near me and he looked dangerous. The dog showed me his teeth and kept acting as if he wanted to eat me. I held a long stick in my hands, I held it like a sword. I think my children were behind my back.*

After Shirin had narrated this dream, the therapist asked her about the feelings she associated with it. Shirin found this dream different from the earlier ones. She was afraid, but not as much as before. "There were at least no dead people in this one" she exclaimed, looking relieved. Her therapist drew her attention to the stick, she had held in her hand. She had used it like a weapon. Shirin was quiet for a moment. Yes, she said at last. I want to fight it, she added. For Shirin, the garden of her parents meant her home country that she could not visit. Though the dog in the dream looked dangerous, more dangerous than the dead people in the earlier dreams, her emotions were different. Wanting to fight the dog to rescue herself and her daughters put her in a stronger, more active role than in the dreams before. Shirin stayed in therapy for 17 additional sessions. During the remainder of therapy no further dreams of dead people occurred. In Session 77, the score of the IES-R was 40.

Therapeutic strategies used. Psychodynamic elements mainly used were the exploration of the attempts of the patient to avoid topics or hinder the progress of therapy, recognition of the client' s defenses and working with them, helping the client become aware of hidden feelings, and the validation and exploration of the client's emotions. Further, the validation of the client's experience of her health problems, and a respectful and appreciative attitude toward her cultural conceptualization of dreams and dream content were essential elements throughout

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therapy. Cognitive elements used were the identification of maladaptive thoughts and beliefs regarding her motherhood, development and reinforcement of parental coping skills, monitoring of her pain, recognition, and decrease of maladaptive behaviors influencing the client's pain. Dream work was loosely based on the Focusing technique (Gendlin, 1986).

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Discussion

The present study examined working with dreams in integrative psychotherapy with clients from Non-Western countries. Cultural traditions, philosophies, and healing practices were made visible through the symbolic meanings the clients appointed their dream material. Discussing the dream content, the emotions, and messages conveyed in the dream further rendered visible the clients' own beliefs and experiences inherited in their cultures. Mutual therapeutic dream work helped clients become aware of alternative meanings incorporated in the dreams and particular aspects of their personal traumatic suffering. Further, a mental health function of dreams was established in the dream work in both case reports. Dream work consisted mainly of a complex exploration of the content and meaning of the nightmares, including special attention directed toward cultural traditional views and narratives. The attention paid to culture bound content was crucial for gaining access to unresolved conflicts regarding the traumatic events in the past.

A culturally sensitive stance in mind the therapist early in the therapy process tried to imply a nonhierarchical relationship between her and Luisa via educating about negative coping responses. The educative manner initiated transference behavior in Luisa, which had to be dealt with before she trusted the therapist with her dreams. When Luisa started talking about her nightmares, she was encouraged to examine her own explanatory model regarding her nightmares and pains, which derived from her native culture. By consciously reflecting on the dream material in a trusting psychotherapeutic relationship Luisa was able to "make connections in a safe place" (Hartmann, 1998). Through the exploration of the dream material she started working through emotions connected to the trauma and found ways for expressing grief and mourning for the losses she had endured. Through the performance of the ritual Luisa enacted a traditional ceremony. The ritual also helped her to process her feelings of shame and guilt that had negatively influenced her life at the time of therapy.

The original traumatic events that were shared in the first case report happened over nine years before the client started psychotherapeutic treatment. If the dreams Luisa brought to the therapy sessions are placed in the context of temporal processing patterns in nightmares after trauma (Hartmann, 1998), she was one step beyond the initial phase after trauma, which Hartmann has described as a fragmented reexperiencing of the trauma in detail. Louisa complained about a recurring nightmare, which on closer examination was not a clear reexperience of the trauma, but contained clear associations to the real life trauma in the dream narrative. With help from the psychotherapist she tried to explore the feelings aroused by the dream and the visual content. In the process, the initial feelings of horror evoked by the nightmare made gradually room for feelings of survival guilt, which she experienced as the dominant emotions in the following dreams. Through

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empathic enquiry the patient was encouraged to share the dream content with the therapist, which first brought a culture-bound interpretation to the surface. Through the validation of the patient and the introduction of new ways of working with dreams in psychotherapy, the patient developed a reflective attitude and was able to explore the dream content mutually with her psychotherapist in a new way. The recurring nightmare did not appear anymore after being discussed in therapy.

In the second case report, Shirin showed a strong reluctance toward discussing her trauma history and she kept cancelling appointments during the first half of therapy. A mutual exploration of a nightmare led to a narration of cultural metaphors for death in Shirin's home country. A connection with her trauma history was established, which she could handle for the first time without an emotional breakdown.

Shirin's dreams clearly reflected emotions related to the trauma and contained persons of the environment she had lived in her home country, who were already dead in real life. Also in this second case, the client was initially untrusting and did not see the benefit of narrating the dreams to her therapist. She interpreted the content according to her cultural traditions. Gradually, through validation of the significance of cultural meaning by the psychotherapist on one side, and the introduction of hope to find relief through the processing of the nightmares and the emotions they evoked, Shirin began processing the material in the sessions. Shirin's view that the dreams were messages from the dead did not change during therapy, but she accepted the dream to serve other purposes as well that were helpful for her in therapy. Shirin's progress during treatment was significantly influenced by gaining insight into the content of the dream she saw between Session 52 und 53. In the sessions following the dream she reflected on the content and reassigned the emotions felt during dreaming into her real life.

In both case reports the nightmares contained associations of the real-life trauma and caused the clients to wake up in the middle of the night, indicating their high vividness, and emotional load. The dreams of both clients were no more fragmented documents of the trauma but involved narrative elements and dream images guided by the emotions to the trauma. Further, in both cases, through integrative dream processing and culturally sensitive therapeutic work the nightmares changed to dreams connecting other, less frightening material or disappeared as a result of dream work in psychotherapy. The dream narratives of both Luisa and Shirin confirm the view that dreams are a creative products of the mind which are not exact replays of waking reality, represented by Hartmann (1996, 2010).

Clinicians should be sensitive about the ethnocultural background of their clients and maintain an interest to the cultural views of their clients and how they make sense of their disorders and give meaning to their experiences and trauma. This kind of "cultural literacy" does seem essential to form effective therapeutic alliances (Alverson et al., 2007). Drawing on the writing of Buhrmann (1984) many cultures place ancestors in a central place in the life of the living and appreciate a form of guidance from the deceased (Buhrmann, 1984). Dreams make the communication between the living and the dead possible in many cultures. The rituals involved with the death of a person, the burial and bereavement, are crucial, all the more in deaths that have occurred surprisingly, by accident or violence. Discussing and sharing rituals, symbols and ways of dealing with loss and death in

the client's cultural environment arose from the material in the dreams of the clients in the two case reports. Both cases illustrate the integration of ethnic cultural values into mainstream psychotherapy through the opportunity of using dream content with its cultural meaning as study material in the collaboration of client and therapist.

Considering psychotherapeutic treatment of traumatized refugee clients from non-Western cultures, Kinzie has highlighted that there is no single trauma or isolated event to which one can be desensitized with the usual PTSD-treatment approaches: instead, there are multiple traumas of catastrophic dimensions that have been survived (Kinzie, 2001). Further, narrating the traumatic events may seem deeply conflicting for the victim. First, it may not be easily understood why returning to the trauma should be helpful for the client, and second, skepticism about the credibility of ones' own story and third, the reactions of the therapist. These stories can be very difficult to listen to and can result in empathetic strain, which may lead to a premature ending of the therapy (Kinzie, 2001). Indeed, especially therapies with refugee torture survivors are prone to end prematurely. Although telling the story of the trauma is in most treatment approaches of crucial importance, the sharing of the emotional experience of the trauma via the dreams can be effective especially in psychotherapy with a multitraumatized refugee client (Cohen, 1999). It is however important to bear in mind that bringing up trauma material through dreams does not imply that the risk of a prematurely terminated therapy has altogether vanished. In the process of exploration of dreams in therapy also the therapist should be aware of the risks of strengthening false memories and the unexpected side effects this could entail for the therapy (Mazzoni, Lombardo, Malvagia, & Loftus, 1999). Integration of a wider number of methods and techniques to help the client adapt to the therapy process is a treatment recommended for special populations as tortured refugees (Drozdek, 2015). Adding cognitive techniques to psychodynamic psychotherapy strengthens and supports coping with difficulties in the present life situation (Matheson, 2011).

In the ethical Guidelines of the International Association for the Study of Dreams, the recognition of meanings and uses of dreams as different across and within cultures is highlighted (International Association for the Study of Dreams, 1997). Taking into consideration the complexity of psychotherapeutic treatment issues when working with immigrants and refugees who live as members of minority groups in a new environment (Nickerson et al., 2011), dream work may be an accessible way to understand and learn about cultural identity and cultural practices, to bridge the gap between cultures, and thus serve as a useful tool in trauma therapy.

Limitations of the Study

The present study is qualitative, using two different case examples as material for its purpose. The observations and conclusions should therefore be viewed in their appropriate context: the material was collected from psychotherapy sessions of two clients. Dream work was an additional tool in integrative psychotherapy and was not conducted in a systematic way but started because the clients mentioned experiencing nightmares. Further, using PTSD measures in a cross-cultural context

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is problematic because symptoms described may not be universally evidenced and translations are difficult (Yeomans & Forman, 2009).

Last, also the method that was chosen for the present study deserves comments. In the cases of the present paper the psychotherapist chose to promote the endorsement of the emotional effects of the dream content, a suggestion deriving from Hartmann (1996). There are also other ways which seem to be working well with victims of trauma: narrative analysis of dreams has been a topic in research literature (Jenkins, 2012), in which the imagination of a dream as story that can be changed, is highlighted as a promising technique. In our cases, the dream work did not include changes to the story or the endings. Nevertheless, working with the dream material produced significant relief of feelings of guilt and a decrease of sleeping problems. Trough the growing globalization and especially the rising numbers of refugees in the Western world an interest and an integration of ethnic issues in psychotherapeutic work grows in importance. When working with a person coming from a different cultural environment, one cannot assume this to be of no relevance. Especially cultural social norms and values, rituals, and symbols (see Hofstede, 1983) should be incorporated.

Conclusion

The main conclusions that can be drawn from this study are the following: it seems useful to combine various approaches in psychotherapeutic work when working with traumatized refugees. A particular psychotherapeutic tool—dream work—that has a strong tradition in Western culture, can be a valuable addition in psychotherapy with clients of African or Middle Eastern background. It seems that many cultures have special theories, beliefs, and rituals concerning dreaming and dreams. However, these various ways of relating to dreams do not present a hindrance for using them also as working material in psychotherapy. It is a hopeful expectation of the authors that this study could serve as an impulse to more studies in the field of dream work in psychotherapy with clients from different cultural backgrounds.

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