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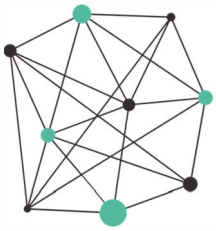

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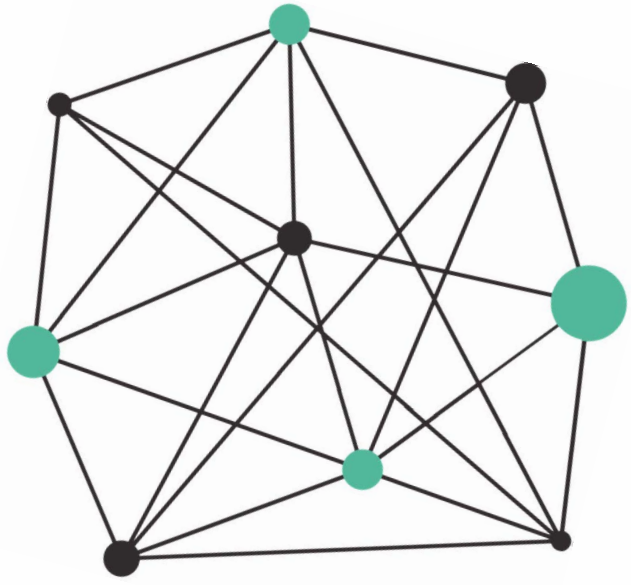

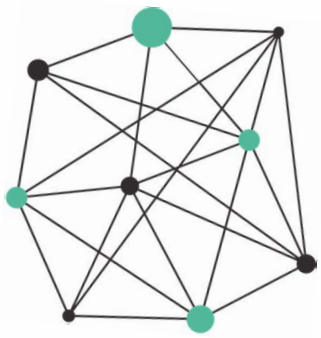

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Content

Nightmares, trauma, and the orthodoxy of narrative

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Abstract

The prevalent view of dreaming in western culture (the 'standard view') has only occasionally been challenged. It suggests dreaming is a perception-like experience that occurs during sleep and is encoded into memory for recall upon waking. A central assumption in therapy for dream symptoms has not been the subject of sustained challenge. It suggests the retelling of dream narratives is required for the treatment of those symptoms. Theories of dreams and their treatment are clinically relevant: nightmares and other sleep disturbances (NSDs) are key symptoms of trauma-related conditions such as PTSD, and trauma is commonplace. However, theoretically well-founded treatments are difficult to find, so confusion around what dreams are and how they can be treated is a pressing matter for the therapeutic trade. We assess a number of assumptions underlying the treatment of NSDs, and argue that these assumptions stem from the 'standard view' of dreaming. We outline theoretical and practical deficiencies in that view and present an alternative on the basis of which divulging dream narratives is not, in principle, required for dreamwork. The alternative view has the potential to increase the range of interventions available for the treatment of NSDs, and thereby to change the nature of interactions with trauma-recovery clients, and others.

1. Introduction

People seeking therapy often present with nightmares, disrupted sleep patterns, night terrors, and other disturbing sleep-related phenomena. These are common symptoms of conditions such as post-traumatic stress disorder (PTSD) (see e.g. Aurora et al., 2010; Pruiksma et al., 2016). In this paper, we assess a number of assumptions underlying the treatment of nightmares and other trauma-related sleep disturbances (NSDs), which give the impression that recounting of dream narrative is the *sine qua non*[1] of working with dreams (*dreamwork*) in psychotherapy and, by extension, working with trauma-related nightmares. After discussing the importance of nightmares as symptoms of trauma-related conditions (Section 2), and remarking on the prevalence of assumptions about dream interpretation and the narrative view (Section 3), we highlight several shortcomings of a widely accepted 'standard view' of dreaming (Section 4) and discuss important connections between trauma, nightmares, and physiological changes (Section 5). In Section 6 we discuss the centrality of narrative to our conceptions of ourselves, and outline ways in which traumatic memory content disrupts ordinary practices that protect those conceptions through narrative construction and revision. In Section 7, we point to an alternative view of dreams and explain how, in principle, it increases therapeutic options for the treatment of NSDs. Finally, we remark upon the literature related to non-narrative interventions that appears to have a bearing on the treatment of NSDs and conclude that there are both theoretical and practical grounds for further research into non-narrative treatments for NSDs.

1 'Without which not' (Latin). A strictly necessary condition; a condition without which something is not possible.

2. Nightmares, dreams and trauma

NSDs are a common symptom of post-traumatic stress disorder (PTSD) and complex traumas.[2] Contemporary research recognises NSDs as a principal feature of PTSD (e.g. Spoormaker & Montgomery, 2008; van der Kolk et al., 1984; Pruiksma et al., 2016), and they are classed as characteristic of PTSD in diagnostic manuals such as DSM-5 (APA, 2013) and ICD-11 (WHO, 2018). DSM-5, for example, lists:

> B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
> 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
> 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content. (APA 2013, p. 271)

These symptoms are prevalent: 50–70% of PTSD sufferers experience nightmares, and some NSDs can continue after other symptoms are alleviated (Spoormaker & Montgomery, 2008; Pruiksma et al., 2016). Treating nightmares directly has been found to reduce both the incidence of nightmares and of PTSD symptoms in general (Davis & Wright, 2007; Moore & Krakow, 2010; Aurora et al., 2010).[3]

The prevalence of trauma puts these numbers in context. An estimated 70% of people worldwide can expect to experience at least one event that fits the 'A1' criterion for a traumatic life event in DSM-5 (Frewen et al., 2019). In the US, around 8 million adults have PTSD per year; 3.5% of the population.[4] And in the UK an estimated one in three people who experience a traumatic event will be affected by PTSD.[5] (And PTSD is not the only trauma-related condition). The number of those affected by NSDs is likely to be considerable.

In short, working with NSDs is an important part of clinicians' work with trauma-recovery clients and ensuring mental health professionals are equipped with appropriate training and resources to work effectively with NSDs is, uncontroversially, a positive goal for therapeutic practices affected. There is evidence, however, that cultures of training and practice around in this area don't always get things right.

A 2017 survey investigating therapists' experiences of working with NSDs[6] suggested that of 146 therapists, only 19.3% thought their formal training provided a good theoretical framework, and appropriate interventions for working with nightmares, whereas 83.4% respondents had clients who presented with nightmares, and 67.6% had clients who presented with recurring dreams. 78% reported that nightmares and sleep disturbances were usually associated with uncomfortable bodily sensations (e.g. pains and tension), but those therapists lacked the confidence to directly work with those sensations as part of their therapeutic interventions.

The lessons we can take from forgoing are relatively straightforward. NSDs are of clear importance in diagnosis and treatment of trauma-related conditions. If the results of the survey are representa-

2 Complex PTSD is a relatively new addition to diagnostic manuals at the time of writing, and is not present in all of the prominent ones. It appears in ICD-11 (WHO 2018), for instance, but not in DSM-5 (APA 2013). Notably—in ICD-11—the 'complex' variant of PTSD has all of the symptoms of PTSD with three additional complicating factors (see WHO 2018). For the purposes of discussion, PTSD will serve as an acronym for both conditions. We indicate where this is not the case.

3 The specific claims here pre-date complex PTSD.

4 See, e.g. https://www.ptsd.va.gov/understand/common/common_adults.asp

5 NHS Choices. (2015) Post Traumatic Stress Disorder. Retrieved from: http://www.nhs.uk/conditions/Post-traumatic-stress-disorder/Pages/Introduction.aspx.

6 The 2017 survey was conducted by Tom Stoneham and Dzmitry Karpuk (Stoneham and Karpuk 2017).

tive of broader trends then, (i) therapists commonly feel under-trained and under-resourced in that area; and (ii) some aspects of the theory and treatment of NSDs have been largely overlooked in theory, training, and treatment cultures.

3. Dream interpretation and the narrative view

Dreams hold a fascination for many cultures. They are sometimes thought of as divination, a means of communicating with other worlds, or means of revealing our character, health, and preoccupations. We like to talk about dreams, are fascinated by our own, and think that others are fascinated by them too (sometimes we are right). Cultures of dream interpretation are both ancient and perennial.

We might think of dream-recounting as a special case of a more general fascination with storytelling. Like other cultural storytelling practices, when a dream is recounted—to oneself or others—its meaning or significance supposedly becomes available for consideration. Dreams, however, don't often naturally make good stories: they are too often incoherent, contain impossible or incredulous events, and have jumbled timelines. So, while it is not unusual to seek the meaning or significance of dreams, it seems unusual that we are tempted to interpret them along narrative lines, as we do with regular stories. We fall into talk of 'beginnings' and 'ends' as we might with a well-crafted novel or play, even though this seldom applies to ordinary dreams, let alone disturbing ones.

This tendency to interpret along narrative lines extends into psychotherapeutic practices: a client presents with a nightmare (a *bad* dream which causes distress and waking), the clinician invites them to recount it, and one or the other engage in interpretation. Given that many forms of therapy offer no theory of dreams, nor preferred ways of working with them (Androutsopolou, 2011), this practice is remarkable. It is all-the-more remarkable for the often-unusual structure and frequent incoherence of the subject matter. Genuinely 'story-like' dreams must account only for a fraction of those we seem to remember, but they dominate our thinking, theorizing, and therapeutic practices. We would do well, then, to ask whether our assumptions and practices in this sphere activity deserve revisiting.

One therapeutic approach famously offers both a theory of dreams, and a way of working with them: *psychoanalysis*, as established by Austrian neurologist Sigmund Freud. Studies into dreams, of course, did not begin or end with Freud—who himself alludes to Ancient Greek and biblical cases—but his psychoanalytic approach had an enduring influence on current dream theory and on psychotherapeutic practice; both psychoanalytic and otherwise.[7] Its influence in non-psychoanalytic circles is likely due to forms of therapy that do not offer a theory of dreams of their own, and thereby source one (inadvertently or otherwise) from a nearby relative. While many will be familiar with 'textbook *Freudian*' views on therapy, some details of Freud's thinking—including a sceptical approach to the possibility of interpreting whole dreams—are sometimes overlooked and are worthy of brief rehearsal.

Freud held the diagnostic potential of dreams in high regard (he called them the 'royal road to the unconscious').[8] They provide access to material that can help us to resolve emotional issues, problems, and fears, and reveal neglected issues that require our attention. Analysis of dreams occurs via interpretation—the therapist listens to a client's dream and interprets it (as occurs still)—but the mechanism that Freud had in mind for interpretation has sometimes been oversimplified.

7 Psychoanalysis has seen a number of branches and developments since Freud's time. We do not intend to give an overview of its history, but use Freudian psychoanalysis as a rare example of a therapeutic approach with an underlying theory and practical guidance related to dreamwork. Plausibly it has contributed to the perpetuation of several assumptions about dreaming, but it is the assumptions themselves—not their genesis—that are of central concern here.

8 Freud is also well-known for his theory of the subconscious (a term he later abandoned for 'unconscious'). We can set aside the details of this for the purposes of discussion and note that, on nearly all conceptions of psychotherapy, the therapeutic process can lead the client to recognise something about themselves which was not apparent to them prior to the therapy.

3.1 Mechanisms of interpretations

Freud (1997/1899) observed that in contrast to 'scientific' theories of dreams—which see dreams as 'somatic process'—lay opinion had always assumed that dreams have a hidden meaning that can be discovered (pp. 10f.). He distinguished between two mechanisms of 'unscientific' interpretation: a process that takes 'dream-content as a whole, and seeks to replace it with another content' (p. 11); and a process that takes a dream as a 'secret code', and the signs in it as items translatable according to 'an established key'. The former can be seen in religious and poetic texts (e.g., Pharaoh's dreams in *Genesis* 41), but that view neglects the fact that most 'artificial dreams' are *constructed* with the intention of revealing a symbolic interpretation. Many *non-artificial* dreams, on the other hand, are both 'unintelligible' and 'confused' and would admit to no such analysis even if a suitable means of interpretation could be determined. The latter mechanism is exemplified in 'dream books'. Via the 'cipher' method, one dreams of *x* and *y*, consults the dream book—a kind of translation manual—and discovers that *x* is translated as *p*, and *y* as *q*. One thereby knows that dreaming of *x* and *y* is related, in some important sense, to *p* and *q*.

Freud took both popular methods to be unworthy of proper discussion (p. 13), but found something worthy of preserving in the 'cipher' method: these 'ancient and stubbornly popular beliefs' contain a truth that is neglected in the scientific view (p. 14); a way of accessing information that might otherwise be withheld, even from a client's own consciousness. In a state of 'reflection', a person might make use of her 'critical faculties' to reject, interrupt, or even completely prevent thoughts from becoming conscious at all. The state of 'self-observation', by contrast, contains significantly less psychic activity, and is almost tranquil (p. 15). Catching a client 'self-observing' is therefore more revealing than catching them 'reflecting', and a client's self-observations about their dreams can reveal the 'thoughts behind' them (p. 17).

Freud did not subscribe, however, to what we might call the 'narrative-interpretation' view of dreams. He states that, 'one cannot make the dream as a whole the object of one's attention, but only the individual components of its content' (p. 17). His method, instead, is concerned with dream-fragments and their associated ideas: an 'interpretation in detail, not *en masse*'. A dream is a 'conglomerate of psychic formations' (p. 17) rather than a neatly packaged story, rich in coherent symbolism.

Whatever the genesis of the narrative-interpretation view, it is not Freud, although his work—along with associates such as Jung,[9] who spoke of dreams as Greek tragedies (see e.g. Jung, 1974, p. 80)—probably contributed to the (re-) propagation of that view. More pertinently, there is little doubt it popularised the notion that therapeutic practice around dreams is inseparable from 'narrative retelling': How else might we 'get at' the relevant dream-fragments for interpretation?

3.2 Underlying assumptions

The salient features of Freud's view for the present discussion are as follows:

(i) *Dreaming* is a 'psychic' or 'psychological' (rather than 'somatic' or 'bodily') process that occurs during sleep;

(ii) *Dreams*—that is, *episodes* of the psychological process of *dreaming*—are encoded into memory during sleep;

(iii) Dreams can be *more-or-less* successfully retrieved from the memory upon waking;

(iv) Dreams are informative about the dreamer, providing special access to hidden or difficult-to-discover aspects of the dreamer's psyche, and their reports can be analysed and interpreted to reveal this information;

9 Jung (1974): 'far from being the confusion of haphazard and meaningless associations … or a result merely of somatic sensations during sleep … is an autonomous and meaningful product of psychic activity, susceptible, like all other psychic functions, of a systematic analysis' (p. 3).

(v) The treatment of dream 'symptoms' (through analysis and interpretation of dream-fragments) *must* proceed via the dream's re-telling.

The first four theses appear to have been inherited by contemporary versions of the 'narrative retelling' view. Freud's reservations about interpreting entire dreams (v) are sometimes overlooked, but the view that the treatment of dreams must proceed via re-telling has rarely, if ever, been systematically challenged. In this paper we challenge a number of the assumptions above and one of our chief objectives is to articulate a primary challenge to the notion that dreamwork *must* proceed via the narrative retelling of dreams.

We call the combination of (i) to (iv) *the standard view of dreaming*.[10] We mean by 'standard view' that a number of models, theories, or practices contain—explicitly or implicitly—all or most of these assumptions. The assumptions make up our *textbook* understanding of dreams and dreaming, and the view has reached far beyond its 19th-century iteration: traces can readily be found in dictionaries, cyclopaediae, and popular culture.[11]

The fifth thesis—at least its non-parenthetical content—is a bit of orthodoxy peculiar to the therapeutic trade; we call this the *doctrine of narrative*. Heavy reliance on narrative is not restricted to the context of nightmares and dreams,[12] but it is in this context that we discuss it here.

In the following sections, we challenge both the *standard view* of dreaming and the *doctrine of narrative*. We argue that the key features of the standard view are controversial, and fail to recognise important characteristics of sleep, dream reports, and of clients presenting with NSDs. If the standard view is incorrect, we argue, the view that the treatment of dream symptoms must proceed via their retelling is also open to defeat.

4. The standard view of dreaming

On the standard view of dreaming, a sleeping person can undergo lengthy and complex perception-like (i.e., *quasi-perceptual*)[13] experiences that have at least a loose narrative structure. Upon waking, they are sometimes able to recall these experiences and to recount them to others in detail. Waking up and 'recalling' the details of a dream, or some of them, is a familiar experience. (Very few people claim never to dream).[14] But the fact that it is a familiar experience can cause us to overlook quite how puzzling an experience, or process, that dreaming is meant to be.

The standard view of dreaming has only periodically been challenged by philosophers, including Norman Malcolm and Daniel Dennett. Malcolm (1959) concluded that no empirical evidence could decide between the views that dreams are experienced during sleep and that they are created upon waking. Dennett (1976) suggested that dreams are like pre-recorded cassettes: 'never dreamed at all but just spuriously "recalled" upon waking'. But dissatisfaction with some assumptions of the standard view predates these works (see e.g. Goblot, 1896; Gregory, 1916). And more recently,

10 Compare with the 'standard model' (Stoneham 2019), which outlines a four-stage process: (1) Dream experiences; (2) Encoding in memory; (3) Recall from memory; (4) Report.

11 The first sentence of the Wikipedia entry on 'Dream' (following the American Heritage Dictionary of English, 4th ed.), defines a dream as 'a succession of images, ideas, emotions, and sensations that usually occur involuntarily in the mind during certain stages of sleep', plausibly cover at least two of the 'standard' assumptions in a single sentence.

12 A version of the doctrine is in play for much talking therapy—especially in those therapies that seek to 'recover' lost or difficult-to-access memories. Whether assumptions about narrative in this broader sense are mistaken is beyond the scope of our current discussion.

13 By the term 'quasi-perceptual', we mean that it 'resembles perceptual experience, but occurs in the absence of the appropriate external stimuli' (see Thomas, 2019).

14 Rare references to those that don't dream include the Atlantes—a culture referred to in Herodotus' Histories (440BCE) who do not 'eat any living thing and never … have any dreams' (BK IV). Buddhist 'saints' (e.g. Arhats), whose minds are 'still', reportedly don't dream having eradicated afflictive emotions such as craving and anxiety. However, since such afflictions are the standard condition of sentient beings, this is compatible with the claim that dream culture is pervasive.

Stoneham (2019) argues that some key assumptions of the standard view are highly questionable. The following highlights some unusual features of the standard view and its implications.

4.1 Dreaming and memory

When we wake up and think about a dream it can, and sometimes does, *feel like* we are remembering an experience that occurred during sleep. But two issues to consider when analysing this occurrence are: (i) if dream reporting is based on a form of memory, then it has noteworthy dissimilarities to other forms of memory; and (ii) the fact that something can *feel like* memory does not settle the matter of whether it *is* memory.

In our memory of daily, waking life, we are often able to remember, sometimes in rich detail, even mundane events that occurred days back (what we had to eat; with whom we spoke). Memory of dreams appears to be much less reliable than this. We are rarely able to recall what we dreamt of some days ago—unless it was striking, we made a personal record, or we shared it with others [15]—let alone the finer features of those dreams: conversations, meal ingredients, attire. Since *bad dreams* are the kinds of things that can noticeably change moods, this apparent amnesia suggests a striking asymmetry with memory for waking events, where emotionally charged events tend to be better retained and more easily retrieved (cf., Shobe & Kihlstrom, 1997).

Memory literature details a number of memory 'varieties':[16] some are purportedly accompanied by a *feeling* (or judgement) that we are remembering, but this is not standardly the case for some kinds of memory,[17] would be an unusual feature in others, and it is arguably not a necessary feature of memory at all. I fondly remember sunny walks on the *Promenade des Anglais*, with associated sights, and feelings, but my recollecting that the *Promenade* is on the *Route Nationale 98* need come with no such associations. Indeed, the latter kind of memory is commonly referred to as 'knowledge', not 'remembering', though in many ordinary cases it is both.[18] In short, sometimes memory *feels like* memory, and sometimes it does not. Notably, some experiences that can feel like memory—such as *déjà vu* and clinical confabulation—are not best thought of as memory at all.

The assumption that dreaming is a quasi-perceptual process encoded in memory does not sit well with what we know about memory, and the fact that thinking about a dream can feel like remembering a nocturnal experience does little to settle the matter of whether remembering is typically what we are up to in those cases.

4.2 Dreaming and culture

The meaning of dreams is culturally variable. In some cultures, dreams connect the dreamer to a spiritual realm: the recently deceased, non-human spirits, or the divine, or they are a means of divination (or, *oneiromancy*). Cultural beliefs and practices around dreams are rich, diverse, and sometimes ancient. By contrast, the standard model of dreams is largely rooted in contemporary western culture and its nascent disciplines.

15 In the latter two cases (and arguably the first) the deployment of more usual varieties of memory—such as semantic or episodic—would explain any improved recollective capacity.

16 Some distinctions are the subject of scrutiny in that literature, though the episodic–semantic distinction, for example, is one of its more enduring features (see e.g. entries in Bernecker and Michaelian 2017; Michaelian and Sutton 2017).

17 Bertrand Russell (1919) and Jordi Fernandez (2019) argue that a 'feeling of pastness' is necessary for "true" and "espisodic" memory respectively. Even restricted claims to essential phenomenology are disputed in the relevant literature (see e.g. Ryle 1949).

18 See, e.g., Ryle (1949), who noted two distinct uses of the verb 'to remember', one of which is an allowable paraphrase of the verb 'to know' (p. 248). There is a tendency in the literature to call this kind of memory 'factual', 'propositional', or 'semantic'.

According to contemporary western culture, dreams are sometimes thought to reveal one's hidden self, or real personality.[19] Such concerns can be found at least as far as Augustine (1955/c.400), who agonised over whether he was culpable for his erotic dreams (Confessions, Bk. 10, Ch. 30).[20] But, by and large, the notion is suspicious (sometimes superstitious): while it is likely responsible for much teenage guilt, there is surprisingly little evidence in its favour, and we should exercise caution around the matter when theorising.

Cultural variation in dream reports is the subject of empirical research, including differences in dream reports around the advent of colour television. For instance, in the 1950s monochrome dreams were thought to be the norm and by the late 1950s it was suspected that dreaming in colour might be diagnostic of psychopathology. However, the incidence of people reporting that they dreamed in colour received a sharp boost in the late 1960s, and a recent attempt to replicate older studies confirm that dreaming in colour is clearly now the norm (see Schwitzgebel, Huang, & Zhou, 2006). A plausible explanation of this effect is that cultural and social factors influence dream reports, but this interpretation is difficult to reconcile with the standard view of dreaming.

4.3 Perception during sleep

While it is tempting to think of sleep as involving more-or-less total cessation of sensory operations, this is an exaggeration. We know that perception remains active (to some degree) because we can be woken by changes in light intensity (e.g., dawn), by background noises (e.g., alarm clocks or the dawn chorus), and other sensations. We also know we continue to be able to detect changes in our bodies—sometimes called interoception—because we learn to awake in response to those sensations (e.g., bladder control, indigestion). In fact, the range of perceptual systems remaining operational during sleep is surprisingly broad. Not only can the sleeping human brain process auditory stimuli (Portas et al., 2000), it can 'perceive' and encode verbal stimuli even in deep sleep (Lasaga & Lasaga, 1973). Low-level perceptual and interoceptive information has a habit of getting into dream reports (see Section 4.4.).

4.4 Perceptual and interoceptive interference

A common challenge for the standard view of dreaming is 'alarm-clock' (or 'pre-cognitive') dreams (see Goblot, 1896; Gregory, 1916). For example, one dreams of a loud explosion—or perhaps some beguiling music—and wakes to find this sound merging with one's blaring alarm clock (Moody & Stoneham, 2017). Phenomena such as these were acknowledged by Freud (1997/1899, Ch. 1),[21] and were recognised in Ancient Greece, where Aristotle observed that perceptual information appears to be amplified and distorted during sleep: 'In sleep … even trifling movements seem considerable … dreamers fancy … that they are walking through fire, and feeling intense heat, where there is only a slight warmth affecting parts of the body' (Aristotle, *On Prophesying by Dreams*, Pt. 1).

These familiar phenomena pose challenges for the standard view. On that view, the temporal coincidence of the explosion or music in dreams with the buzzing of the alarm clock seems to require that the dreamer 'predicts' the alarm was about to buzz. And this is implausible enough. But if the phenomenon is as commonplace as it appears to be, then a substantial amount of 'live' perceptual

19 In a rare, brief, example of support for this claim Katz and Shapiro (1993) refer to dreams indicating 'personality traits' by pointing to the example of Alexithymia—an 'hypothesized stable personality trait' marked by 'inability to be aware of and communicate emotional states … little or no fantasy life, impoverished dreams, and a tendency to mundane operational thinking' (p. 995). However, this relies on a technical sense of the term 'personality trait, unlikely to be embedded in the common notion of *personality*. In any case, the example does not support broader claims about dreams revealing personality.

20 'These things rush into my thoughts with no power when I am awake; but in sleep they rush in not only so as to give pleasure, but even to obtain consent and what very closely resembles the deed itself … Am I not myself at such a time, Oh Lord my God?' (Confessions, 10.30.41).

21 In Maury's dream, a detailed and terrifying nightmare culminates in a guillotine's blade severing his neck from his trunk just as a part of his bed strikes him in the same spot. 'The curtain-poll CHANCING to hit Maury's neck as he dreamed of the descending knife', as Gregory (1916) puts it, is 'out of the question' (p. 194).

information—both 'exteroceptive' and 'interoceptive'; distorted or otherwise—can and does form a part of dream reports. And this is hard to reconcile with the view that dreaming is a predominantly *psychic* (or psychological)—rather than bodily (or *somatic*)—phenomenon, especially for cases in which interoceptive information, which primarily relates to bodily change, is prominent in reported content. In such cases it is tempting to say instead either that 'the disturbance at once awakens the sleeper and produces the dream' (Gregory, 1916), or—where waking is not immediate—that 'bodily sensations' and 'somnolent perceptions' are 'key elements in the construction of dream narrative' (Karpuk, Stoneham & Davies, 2019). But in either case the sense in which dreams are meant to be predominantly psychic formations is either lost or diluted.

The assumptions of the standard view are questionable on several grounds. It is by no means clear that we should think of dreams as 'memories' at all, let alone memories of sleep experiences. Cultural factors and social expectations find their way into dream reports. Senses continue to operate during sleep, and *sensations*—usually distorted—are key elements of dream reports. A proportion of those sensations are straightforwardly physiological rather than psychological (cf. Section 5).

The confluence of influences in dream reports are not accounted for by the standard view, and so the view is an insufficient explanation of the familiar phenomena that occur in dream reports. While these considerations fall short of demonstrating that the standard view is false, because it is an insufficient explanation of dream reports, its influence on psychotherapeutic practice might be treated more circumspectly than it has been (especially given the prevalence of trauma and the sensitive nature of interactions with trauma victims). Theoretically speaking, we are in a good position to question whether the standard view is the correct view, and to consider what dreams might be if they are not what that view supposes.

5. Nightmares, trauma and the body

In the first section we talked briefly about the presence of uncomfortable bodily sensations—such as pains and tensions—that are associated with NSDs. We mentioned that therapists often lack the confidence to work directly with those sensations as part of their therapeutic interventions. Plausibly, this is related to the overtly *psychic* understanding of dreams on the standard model. We now say more about the importance of the physiological component of dreams and trauma. We highlight several examples in which narrative retelling is arguably inappropriate, challenging, or unhelpful, and point to developments in the history of trauma therapy that emphasise the importance of the physiological components of trauma.

Freud and some of his colleagues favoured a predominantly 'psychic' (psychological) understanding of dreams, as opposed to a 'somatic' (bodily) one. In Freud's own case disavowing the importance of the bodily in dreams is a result of his commitment to the possibility of dream interpretation: a somatic (or 'scientific') understanding of dreams—by his lights—would makes dream interpretation impossible (see Freud 1997/1899, Ch. 1).[22]

The difficulty we face is that a psychological understanding of dreams appears at odds, firstly, with our understanding of familiar dream phenomena; and secondly, with a failure of trauma-related dreams to meet the ordinary conditions for interpretation (i.e. symbolism and wish-fulfilment); and, finally, with a contemporary understanding of trauma and trauma-related conditions as having an *essentially* bodily component. Many researchers now suggest that the treatment of PTSD should be 'body-oriented' because *trauma response* is largely physiological (e.g. van der Kolk, 2002). A pressing question for the (trauma-) therapeutic industry, then, is whether the 'narrative retelling' method of dreamwork can address the physiological, as well as psychological responses to trauma.

22 This is all the more puzzling due to his own discussion of Aristotle's observations, and of pre-cognitive dreams.

In response to this question, we can note some reasonable limits on what we can expect from narrative retelling in general. Ostensibly, there are clear cases in which a narrative treatment of trauma generally, and nightmares specifically, look to present difficulties or challenges. These can be due to the nature of the trauma, cultural differences, or perceived risk to the client.

A straightforward case can be found in the treatment of pre-verbal trauma, where there is no retrievable (semantically encoded) narrative, and so alternative interventions must be found.[23] Narrative interventions can also prove difficult in cases where the client doesn't have a strong sense of 'life narrative'.[24] Nightmare-specific examples of difficulties arising from trauma can occur with clients from cultures with sensitivities around the verbalization of nightmare content: nightmares of some varieties might be culturally undesirable, and recounting their content might thereby require *ritual*—rather than a therapeutic—intervention.[25] Finally, there appears to be a genuine prospect of harm to the trauma-recovery client, either through adverse reactions such as re-traumatisation, or through client-initiated premature termination of treatment (dropout).[26] Narrative retelling is plausibly related to re-traumatisation in a number of clinical and non-clinical contexts.[27] (Narratives can be powerful triggers!) And there is evidence to suggest that dropout rates are higher for narrative-focused treatments compared to 'non-narrative' interventions (see Imel et al., 2013; Section 7). These cases should be sufficient to elicit a degree of caution with regards to the deployment of narrative-focused treatments in trauma-recovery contexts.

5.1 The somatic character of dreams

Remarks on the somatic character of dreams can be traced at least as far as Hippocrates (Regimen IV, or *Dreams*) and Aristotle (*On Prophesying by Dreams*). Aristotle proposed an explanation of how dreams can be diagnostically relevant: the bodily 'movements' at the beginnings of diseases are 'small' and while such movements are available to the waking mind, they are 'lost sight of in contrast with waking movements'. Only when these bodily movements are 'very great' or 'violent' are they likely to be detected against the background noise of waking life (*Ibid.*; cf. Section 4.4)

Hippocrates believed the mind to express the state of the body by way of dreams, and took them to be medical indications. 'Healthy' dreams are relatively mundane; following the actions of the day. Dreams that run 'contrary to the acts of the day' and contain 'struggle or triumph' indicate a 'disturbance in the body' (*Dreams,* LXXXVI). Certain dream content indicates a 'disturbance of the soul' *(psyche*) (LXXXIX).

Galen (*On Diagnosis in Dreams*; ODiD) noted that a dream (*enhypnion*; or 'vision-in-sleep') is a 'disposition of body', and thus diagnosis requires attention to 'nourishment that has been taken'. He highlights complicating factors due to habit and memory,[28] on the basis of which diagnosis becomes

23 Thanks to Danielle Tanner for this example. See also van der Kolk and Fisler on global memory impairment due to childhood trauma: 'It is likely that the combination of autobiographical memory gaps and continued reliance on dissociation makes it very hard for these patients to reconstruct a precise account of both their past and current reality' (1995).

24 This is sometimes the case with trauma clients who have been adopted and/or through numerous foster homes (see fn. 25)

25 These examples (among others) come courtesy of a knowledge exchange event hosted by the Department of Philosophy, University of York which hosted a number of experienced clinicians.

26 According to our 2019 survey (Davies, Karpuk and Stoneham, 2019), a small proportion of clinicians take re-traumatisation—or symptom-exacerbation—to be a natural or inevitable part of treatment. Re-traumatisation was seen predominantly—either explicitly, or by association—as a negative event or outcome: 70.2% of participants associated it with a 'negative/adverse event'; and 62.3% with 'unscheduled absence from therapy'.

27 A recent example of this connection in a non-therapeutic context is the VC-CIC report 'Compensation without re-traumatisation' (2019). Re-traumatisation's connection to narrative appears to be accepted in a number of non-therapeutic contexts, such as Truth and Reconciliation Committees in post-apartheid South Africa, and in therapeutic contexts (see e.g. Mailloux, 2013). However, empirical research on re-traumatisation has been hampered by a lack of agreement and clarity around the term (see e.g. Layne et al., 2006).

28 'things habitually done by us day by day, and some from what we have thought' (Galen, ODiD).

'more difficult' because it is not easy to say how content from multiple sources might be distinguished.[29] He also provides a helpful illustration of the dangers of (*psychic*) interpretation for ostensibly somatic causes: 'a man dreamed that one of his legs had turned to stone, and many of those clever about such matters judged that the dream pertained to his slaves, but the man was paralyzed in that leg, although none of us expected that' (ODiD).

The notions of dreams as indicators of physiological change and pathology survives beyond the Greek and Roman analysis. As Haskell (1985) notes, 'Dreams are exemplars of psycho-somatic/somotopsychic [*sic*] relationship' (p. 47), and reminds us of their dramatic effects:

> Few people have not had the experience of awakening from a dream, or nightmare, with their adrenal glands pumping stress hormones into their system, with their heart rate considerably accelerated, feeling their pulse pounding in their temples, perhaps short of breath, and while not directly aware of it with their blood pressure climbing to abnormal levels. (Haskell, 1985, p. 47)

Sleep and dreams have important consequences for physical health, and potentially dangerous consequences for those with existing pathology (*Ibid.*). Contemporary research suggests that physical illness can alter dream content. Katz and Shapiro (1993) point to a number of ways in which dreams may either reflect the presence of organic disease or cause/precipitate organic disease (pp. 993–995). Bugalho and Paiva (2011) found 'a pattern of dream alteration … related to more severe frontal dysfunction' in subjects with Parkinson's disease (p. 1613).[30]

As with trauma-related nightmares, dream content with ostensibly organic causes presents a difficulty for interpretation on the basis of both symbolism and wish-fulfilment. But it also presents a more general problem for the psychotherapeutic value of *listening* to clients' dream narratives. The substantively somatic character of dreams significantly downgrades the value of dream narratives for the purposes of (*psychic*) interpretation (even if dream reporting were eventually to become a reliable marker of organic disease). Thus, any psychotherapeutic benefit from recounting dream narratives must be on the side of the client. But, in trauma-recovery clients, this should be weighed against the potential for harm (see our remarks in Section 5, above, and in Section 6).

5.2 Dreams, trauma and body-oriented therapy

The suggestion that dreams reveal something hidden also rubs against contemporary knowledge and treatment of PTSD, and other trauma-related conditions that result in NSDs. In trauma-related cases, it is neither helpful nor plausible to suppose that debilitating sleep disturbances are reflective of an individual's true character as opposed to the bare result of their traumatic experiences. And Freud himself struggled to reconcile this aspect of trauma-related dreams with his broader outlook when encountering traumatised WWI veterans. Trauma-related dreams—symptoms of 'accident neurosis' and 'war neurosis' (Freud, 1920)—are neither 'symbols' nor 'wishes', but 'history',[31] and hence cannot be analysed in terms of unconscious content (see Caruth, 1995, p. 5). Beyond the innocuous sense in which a biography might reveal such details, there is little to be said for the claim that traumatic memory intrusions reveal something 'hidden' about the person. Correspondingly, there is little to be said for the view that dream alterations (putatively) caused by organic disease might reveal unconscious desires, etc.

Perhaps in light of these complications, there is a considerable literature highlighting the importance

29 Galen takes the most troublesome to be prophetic dreams, and though we can leave those aside for the purposes of this discussion, the general point remains.

30 This study found alterations to be characterised by 'heightened aggressiveness and the presence of animals' (p. 1613).

31 That is, intrusive repetitions of the traumatic experience or experiences.

of body-oriented—as opposed to narrative-oriented—treatments for trauma-recovery clients, that can be traced at least to Wilhelm Reich, once employed in Freud's Vienna clinic. Reich relates character to body, as well as to psychology (see e.g. Reich, 1933), and suggested that character traits are stored in the body, finding expression in how the body is held. In psychic disturbances, 'biological energy' is bound up in both symptoms and muscular rigidities, which he called 'muscular armour'.[32]

Reich's work was continued by his student Alexander Lowin who coined the term 'body language' and founded a form of body psychotherapy called *Bioenergetic Analysis* (BA). BA is based on the importance of continuity between body and mind and the notion that the body is important in the therapeutic process because 'every profound change has an impact on the body'.[33] Reich's and Lowin's work emphasises the importance of bodily symptoms both in diagnosis and the treatment of clients, suggesting that the therapeutic lacuna left in cases unsuited to narrative-focused treatment can be filled in other ways.

Philosopher-turned-psychotherapist Eugene Gendlin found—under psychologist Carl Rogers—that the power to bring about 'lasting' and 'positive' change in psychotherapy depends upon the client's ability to access the non-verbal ('bodily feel') of the issues that trouble them.[34] Gendlin applied the importance of the body in therapy to working with dreams. He continues Freud's and Jung's theme of working with dreams as a way to 'engender something to break through "directly from the unconscious"' (Gendlin, 2012), but suggests that attention on the body can be contrasted with 'mere talk': the body contains more information than one 'knows' (i.e. verbally) because our bodies 'interact directly in our situations in many intricate ways that we don't (aren't able to) think about separately'. Gendlin's *body dreamwork* retains elements of the narrative and interpretive approaches, but with notable developments. Although there is space for dream narratives to be recounted to the therapist, questions directed at clients tend to be phrased in the present tense, and to focus on objects or characters and their relation to the clients and their bodies rather than on the 'story-plots' of the dreams (see e.g. Gendlin, 1986, Ch. 2). Importantly, the dream is treated not as a fixed past event—which can be correctly or incorrectly retold as the standard view of dreaming implies—but as a live process in which details change or continue to develop (*Ibid.*).

5.3 Taking stock

There are limits on the contexts in which a predominantly narrative approach might be thought a helpful intervention, both generally in the treatment of trauma-related conditions, and specifically in the treatment of NSDs. There are also perceived (and plausible) connections between narrative retelling, re-traumatisation, and dropout, both in non-therapeutic and therapeutic contexts. Trauma-related nightmares, meanwhile, plausibly fail to meet the conditions for interpretation: they are commonly intrusive memories. Meanwhile, research into dreams and organic illnesses suggests a tighter connection between physiological changes and conditions and dream content (see 5.1; see also 4.4). Together, these downgrade the plausibility of (predominantly psychic) interpretation and restrict the value of narrative sharing.

Literature and research that emphasises the bodily aspects of trauma-related conditions, and specific approaches to therapy that focus on the body and bodily sensations in their interventions, suggest that narrative is, in principle, neither the *sine qua non* of psychotherapy, nor of dreamwork. Narrative interventions for dreamwork are neither obviously necessary, nor obviously suitable for all cases in which dreamwork is desirable—notably in the treatment of trauma-related NSDs. We might tentatively conclude, then, that there is good reason to look beyond predominantly narrative interventions, and to be cautious of overwhelming emphasis on narrative in the treatment of trauma-related NSDs.

32 See www.wilhelmreichtrust.org/biography.html which includes an in-depth biography of Reich.

33 See http://www.bioenergetic-therapy.com/index.php/en/

34 See www.focusing.org/gendlin.

However, since narrative is held in high esteem psychotherapy, and elsewhere, this is an unusual result and one that might benefit from further argument. In the next section, we reflect on the importance of narrative, and consider how this relates to traumatising experiences.

6. Narratives, self and traumatic content

Self-narratives—loosely, the stories of our lives—are importantly connected to our *senses of self.* We exchange stories about many aspects of our lives—actions, character traits, decisions—and find it odd when someone cannot (especially in the latter case). Narrative discourse allows us to make sense of human action and the passage of time, and order actions in a way where one event happens 'not just after something else, but because of something else' (Pellauer & Dauenhauer, 2016). Narrative is so valuable to us in that respect that some believe the primary function of autobiographical memory is not to retain information that reflects the past—a standard assumption about memory—but to *protect* coherent pictures of ourselves (e.g. Conway, 2005). And because narratives are of such central importance to this sense of self, it is understandable that many approaches to therapy require clients to *share* those narratives. Indeed, for some approaches to therapy, this kind of sharing is the only, or most important, intervention. Challenging the role of narrative in the treatment of trauma victims, then, might look odd. But traumatic experiences are precisely the kinds of experiences that cannot easily be incorporated into our ordinary sense of self, at least not without potentially negative consequences. For instance, memories of trauma can form reference points for the organisation of other experiences, meaning that:

> a highly negative, unpredictable, and probably rare event will influence the attribution of meaning to other more mundane events as well as the generation of expectations for future events. Ruminations, unnecessary worries, and compulsive attempts at avoiding similar events in the future are likely outcomes. (Bernsten & Rubin, 2006, p. 219).

So, while narratives generally have a central importance to our sense of self, the integration of trauma content to these narratives can be harmful for mental health (*Ibid.*): it can *tyrannise* non-traumatic content. We can briefly say a little about ordinary mechanisms to protect the sense of self that are not always available for trauma content.

6.1 Mechanisms that protect the sense of self

We all have experiences that do not fit our narratives: one might fail an exam while maintaining that one is 'a good student', fail to get a job while maintaining that one is 'a successful person', and so forth. What allows us to continue to think of ourselves as having certain characteristics and traits while, at the same time, being faced with evidence to the contrary is a series of mechanisms that enable us either to make sense of, or not to focus excessively upon, counterexamples to the pictures of ourselves that we have formed. These mechanisms include:

1. *Forgetting*—in cases where the counterexample is sufficiently trivial (e.g. we see ourselves as reliable even though we missed a train) we might simply forget the disconfirming evidence.
2. *Excluding*—we might avoid actively recalling the offending event and thereby exclude the event from our narrative.
3. *Re-structuring*—we might restructure the narrative to include the event that would otherwise rub against our sense of self (e.g. 'the job wasn't right for me'; 'I don't perform well in exams')

In each of these cases, events and evidence that might otherwise count against our general view of ourselves is either eliminated, managed, or incorporated into our narrative, thus protecting our sense of self. However, because trauma content is domineering, these kinds of ordinary coping mechanisms are largely unavailable. Instead of neatly folding into a self-narrative, trauma content can force a disproportionate reconstruction of that narrative. (This is one of the reasons why trauma can be so devastating.)

6.2 Narratives and the therapeutic mechanism

Trauma therapy often ostensibly works by 'reprocessing'[35] traumatic material into a material a client can live with. In that sense it requires a degree of exposure to that material. This exposure is commonly achieved by *talking through* (and sometimes *pausing on*) the traumatic material, either from life events or nightmares. That is the narrative approach to working with trauma (though many approaches make good use of narratives), and we can accept for the sake of argument the assumption that the therapeutic mechanism—whatever it is—requires exposure to traumatic material.

There is an important distinction, however, between a *therapeutic mechanism* and its mode (or method) of delivery. We ought not to conclude that *narrative* exposure is the mechanism that exacts therapeutic change from the simple fact that narrative is one method to elicit exposure to traumatic material.

On the contrary, champions of forms of therapy that rely heavily upon narrative—such as cognitive behavioural therapy (CBT)—have sometimes agreed that 'mental activity may take the form of words and phrases (verbal cognitions) or images (visual cognitions)'; that 'distress can be directly linked to visual cognitions—as well as to verbal cognitions'; and that 'modifying upsetting visual cognitions can lead to significant cognitive and emotional shifts' (Holmes et al. 2007, p. 298).[36] Holmes et al. (2007) go further, suggesting that:

> since much of the cognitive-affective disturbance associated with intrusive trauma-related memories is embedded in the traumatic images themselves, directly challenging and modifying the traumatic imagery becomes a powerful, if not preferred, means of processing the traumatic material. (Holmes et al. 2007, p. 298)[37]

Plausibly, 'directly' in this passage implies that it is possible without narrative re-telling. But in any case, mental imagery is a putatively important aspect of trauma-related mentation, and a (contingently) strong reliance on narrative for exposure purposes does not imply it is the only or necessary means of exposure. Nor does it imply that narrative is the therapeutic mechanism itself. And this can be taken to suggest either that there are multiple therapeutic mechanisms—one for 'imagistic'; one for 'verbal' cognitions, etc.—or that one underlying mechanism works in both cases. (For the purposes of this discussion, we need not select between these options, nor defend a specific theory of therapeutic reprocessing.)

6.3 A final dogma of narrative dreamwork

An obstacle that remains in challenging the role of narrative in the treatment of NSDs is this: on the assumption that the standard view of dreams is even 'ball-park' correct, it still makes sense to inquire about the narrative of clients' nightmares because it is the most effective—plausibly the only—way to access the unconscious processing that results in dreams. After all, if dreaming is roughly what the standard model supposes, then dream narratives are (sci-fi aside) our only access to the *causes* of dreams.

So far, while we have outlined several challenges to the standard view, we have not offered a plausible alternative, and have thus not addressed this residual attraction to the notion that dreams are a fine route to material that is otherwise unavailable or difficult to access.

35 'Re-processing', as with several terms in the psychotherapeutic lexicon, appears widespread in the field, but not particularly well-defined, plausibly because they are relatively new terms of art ("jargon") or, existing terms with new ("lexically innovative") meanings (cf., 're-traumatisation' as an example of the former). Both neologism, and lexical innovation can give rise to ambiguity (cf., Carston, 2020).

36 Holmes et al. (2007) are discussing the views of Beck (1976) and Beck, Emery, and Greenberg (1985), highlighting the fact that mental imagery has been in the genes of cognitive behavioural therapy from its inception (p. 298) despite practices up to that point, and perhaps now, implying an almost exclusive focus on verbal cognition.

37 Here discussing the work of Smucker (1997).

In Section 7, we outline an alternative view of dreams that addresses this final concern, and which explains many of the familiar phenomena we saw in the discussion of dream reports above (Section 4). In Section 7.1, we argue that an alternative view of dreams can increase our therapeutic options for the treatment of trauma-related NSDs; preserve what is culturally important about dreams and their retelling; and is culturally sensitive, allowing for treatment of nightmares in a diverse client-base. In Section 7.2, we briefly explain how the alternative view of dreams increases the therapeutic options available for dreamwork. In Section 7.3 we survey literature related to non-narrative trauma therapy, and conclude that further research into non-narrative treatments for NSDs is warranted.

7. An alternative view of dreams and their treatment

Dreams are both culturally and therapeutically relevant: culturally relevant in the sense that sharing our dream reports—and, often, attaching some significance to them—is a near-universal practice among humans; therapeutically relevant in the sense that bad and disturbing dreams are a key symptom of trauma-related conditions. But because many forms of therapy don't have a dream theory of their own, nor a preferred way of working with dreams (Androutsopolou, 2011; Section 3 above), the therapeutic significance of dreams is difficult to translate into therapeutic practice. This is unlikely to change while the standard view of dreams is both questionable and culturally specific. Dreams are a far more complicated phenomenon than the prevalent view suggests.

Earlier, we outlined some familiar characteristics of dream reports that don't fit well with the standard view. Once these are taken into account, the picture that emerges is one in which dream reports are influenced by cultural associations, social factors, *actual* perceptual (and interoceptive) information, and life events. The standard view doesn't explain how these factors could influence dream reports, and this is a good reason to explore alternative explanations of dream reports. One recent alternative is the Cultural–Social model (CSM) of dreams (Stoneham, 2019). We briefly outline CSM in Section 7.1 before explaining how adopting CSM expands therapeutic options around the treatment of NSDs.

7.1 Dreams without dreaming

Following Malcolm (1959) and Dennett (1976), Stoneham's (2019) CSM emphasises a distinction between *dreaming*—the putative quasi-perceptual experience that occurs during sleep discussed above; and *dreams*—the 'everyday account of an experience … as having occurred during sleep' (Foulkes, 1999). On Stoneham's view, dream reports are constructed upon waking from a confluence of (actual) somnolent perceptions and interoceptions; a specific dream culture; social expectations about what dream reports are meant to be like; and other life events and preoccupations.

Distinctively among alternative views of dreams, CSM recognises the importance of the cultural context in which dreams occur, thereby helping to explain both why dream reporting is widespread, and why views on what dreams are (and what they are for) vary dramatically across cultures. Stoneham's model preserves the cultural and personal significance of dream reports, but without a commitment to a mysterious quasi-perceptual experience (*dreaming*) that occurs, and is encoded into memory, during sleep. So, we have *dreams* without *dreaming* (Stoneham, 2019, p. 9).

CSM has a number of advantages over the standard view. It explains why dream 'memories' aren't like actual memories; why there is cultural variation in dream reports; and how low-level perceptual data from sleep influences dream report content. Since these phenomena are not explained by the standard view, CSM is, at least, a plausible alternative model of dreams and thereby worthy of exploration (*Ibid.*)

7.2 Dreams and therapeutic options

A striking feature of CSM is that it would appear to have implications for therapeutic interactions with trauma-recovery clients. Recall that, on the standard view, the dream report is a ready source of reliable *psychological* data about a client, which is otherwise difficult to obtain: dream narrative is our

only access to the *causes* of the dream. So, on that view, it doesn't make sense to consider a clinical alternative to re-telling. On CSM, however, a dream report is constructed partly from nocturnal (low-level sensuous and bodily) content and from waking content (cultural, social, and 'live' memory)[38] that is available via other means. Dreams still say something about a person on this view—in the way that jokes and conversations do (Stoneham, 2019)—but they are equally confused or distorted records of bodily and environmental changes that occurred during sleep. Their appeal as a uniquely revealing source of psychological data about an individual is, therefore, markedly diminished, and on this model, in principle, one would not need to hear a dream narrative to treat NSDs.

On the face of it CSM might appear to indicate a loss to psychotherapy: dream reports—a resource once thought rich in salient, and otherwise inaccessible, data; ripe for expert interpretation—are not what we have taken them to be. However, (i) the notion of 'expert interpretation' of dreams should be treated circumspectly, at least nowadays; (ii) the suggestion that narrative exposure is the only plausible therapeutic mechanism appears to be incorrect; and (iii) the notion that narrative exposure is the only viable means of deploying a therapeutic mechanism is suspect. Disabused of these assumptions, clinicians are in principle able to avail themselves of a greater range of therapeutic interventions. And increasing the range of options is desirable when interacting with trauma-recovery clients for whom revealing details of nightmares can be deeply distressing, or deleterious to health or social standing. In Section 7.3, we briefly comment on the literature relevant to non-narrative treatments for NSDs.

7.3 Alternatives to narrative-focused treatment and NSDs

It is a mark of the prevalence of the standard view that research focusing on the treatment of nightmares in ways that *exclude* recounted narratives is difficult to find, but there is a burgeoning body of literature that bears upon the issue. Imel et al. (2013), for instance, found that when compared to narrative approaches, non-narrative interventions for PTSD resulted in lower levels of dropout (also Frost et al., 2014). Imel et al. (2013) draw a distinction between 'trauma-focused' (or trauma-specific) and 'trauma-avoidant' interventions (p. 394), and describe several levels of 'trauma focus', including: '(a) treatments that primarily focus on retelling the traumatic event, (b) treatments that do not focus on retelling but allow discussion of the trauma, (c) treatments that refrain from any discussion of trauma' (p. 396). Although these categories contain ambiguities (especially '(b)'), it is clear that (a) would count as what we have called a 'narrative' approach, and (c) would count as what we have called 'non-narrative'. Imel et al. found that narrative interventions had a higher rate of dropout when compared to non-narrative interventions. In some cases, the difference was as high as 14% (pp. 400f.; also Frost, et al. 2014).

Canonical examples of narrative therapy are easy to find, for example, trauma-focused cognitive behavioural therapy (TFCBT)[39] and narrative exposure therapy (NET, which is based on TFCBT). As far as we are aware, TFCBT (and CBT more broadly) posits no theory of dreams, nor preferred interventions directed at their treatment.

Isolating examples of non-narrative therapy (let alone non-narrative therapies for NSDs) is more complicated. One complication is that real-world therapies are unlikely to *prohibit* discussion of traumatic experiences in a way that clinical trials might demand (Imel et al., 2013, p. 401). Another is that narrative is sometimes 'smuggled' into the procedures for prima facie non-narrative—or 'narrative neutral'[40]—interventions. For example, eye movement desensitization and reprocessing (EMDR) is, on its face, either non-narrative, or narrative neutral. Although no precise therapeutic mechanism was initially posited, it was assumed that eye movements are efficacious in leading to 'clinical improvement' (Stickgold, 2002). Accordingly, subsequent attempts to explain the efficacy of EMDR have run with that assumption (see Stickgold 2002 for one putative mechanism).

38 'Nocturnal' is a gloss for 'during sleep' here.

39 See Lely et al. (2019).

40 Plausibly, therapies that do not rely upon, but allow discussion of trauma narratives (see Imel et al. 2013).

However, EMDR incorporates a good deal of what is ordinarily classified as narrative therapy. A sample summary of the method (McFarlane & Yehuda, 2000), includes a stage during which the client 'describes the traumatic event and the associated feelings' (p. 944). And, although EMDR is generally thought to be efficacious, overall, the eye movements themselves are not: they have no 'incremental' effect compared to the same procedure when used without them. Thus, the eye movements 'integral to the treatment, and to its name, are unnecessary' (Davidson & Parker, 2001, p. 305). Plausibly, what is efficacious about EMDR is precisely what is efficacious about its narrative interventions (the eye movements are superfluous). As might be predicted on that basis, some meta-analytic comparisons show no significant difference in efficacy between EMDR and TFCBT (see e.g. Seidler & Wagner, 2006).

Perhaps the clearest example of a non-narrative treatment is *present-centred therapy* (PCT). It is 'exclusively non-narrative' by design. PCT was initially developed as a non-narrative control condition for clinical trials and includes, 'psychoeducation about PTSD and homework assignments targeting current maladaptive relational patterns by including problem-solving techniques, and helps patients to focus on the here and now' (Lely et al., 2019, p. 370).

In a randomised control trial (Lely et al. 2019), PCT was found to be an 'effective and safe' psychotherapeutic method for the treatment of PTSD (Lely et al., 2019, p. 375). These findings corroborate meta-analyses by Frost et al. (2014) who concluded that PCT is also a potential solution to the 'particularly troublesome issue' that 'despite the proven efficacy of various [PTSD] treatments, many patients drop out from these treatments' (Frost et al., 2014, p. 1; cf. Imel et al., 2013). Dropout (*Ibid.*)—and even lack of consent (McFarlane & Yehuda, 2000, p. 943)—are a problem for some effective narrative-focused therapies. With comparatively lower levels of dropout, PCT appears to be 'acceptable' as well as 'effective and safe', thus providing evidence of an advantage for non-narrative interventions over narrative competitors.

PCT also has drawbacks, however. Despite differing from other psychological controls in a number of respects—including a 'cogent rationale', and relatively well-developed training and materials (Imel et al., 2013)—PCT's genesis is likely to count against it becoming a widely-accepted treatment (*Ibid.*); PCT treatments have a number of 'ingredients', and more research is required to establish which are of therapeutic value (Frost et al., 2014, p. 6);[41] there is no data on PCT as a treatment for NSD symptoms; and the plausibility of a complete exclusion of *exposure* to traumatic material is, perhaps, exaggerated.[42]

A non-narrative form of NSD therapy that makes no claims to complete exclusion of traumatic content is systemic experiential embodied reprocessing (SEER). SEER was specifically designed to address high dropout rates in narrative-focused therapies, and to minimise the possibility of negative outcomes such as re-traumatisation. A distinctive feature of SEER—as a result of therapy-craft rather than contrivance—is that clients are never required to recount the traumatic (nightmare) narrative. Instead of dream narratives or events, the method focuses on emotionally neutral present-tense descriptions of dream objects (and places, and people), and on the development of the client's 'bodily' awareness. During therapy, emphasis is placed on the bodily sensations and the current reactions that are associated with dream objects, and the therapist facilitates an internal dialogue with these sensations and reactions that occurs—as with PCT—in the 'here and now'. It provides a unique way to utilise 'pre-reflective and preverbal reactions of the body towards a certain situation' (Karpuk, Stoneham & Davies, 2019, p. 37).

Although the method appears distinctive among approaches to dreamwork, its influences can be readily seen in a number of interventions and approaches discussed above (see e.g. Section 5.2).

41 Importantly, Frost et al. (2014) note significant variation in 'trauma-focused' treatments, including occasional switches to non-narrative variants and changes to guidance over time (p. 6).

42 Among other complicating factors, there is evidence to suggest that traumatic memory content is well-retained, easily recalled (Shobe and Kihlstrom, 1997), and prone to involuntary intrusion (see e.g. APA, 2013).

The method appears to rely upon non-narrative exposure to traumatic content, managing clients' contact with that content through a number of devices, including present-tense, third-person dialogue (*Ibid.*). And because the method doesn't suppose a novel or alternative therapeutic mechanism—it is potentially compatible with a surprisingly diverse range of existing therapeutic approaches. Research into the effectiveness of SEER is, at present, in its infancy. So far, it includes promising testimonial evidence gathered via semi-structured interviews, and reports of efficacy in surveys of self-selecting practitioners. However, at the time of writing, there have been no independent assessments of efficacy or randomised control trials.

The literature above suggests solid practical reasons to explore the viability of non-narrative treatments for NSDs and, if we are correct, there are no theoretical obstacles to their use if one adopts CSM rather than the standard model. At the moment, however, our finest example of non-narrative intervention for trauma (PCT) has not been tested as a treatment for NSDs, and research into the efficacy of a promising non-narrative intervention for NSDs (SEER) is still in its infancy. Although, in principle, abandoning several widespread assumptions about dreams increases therapeutic options for the treatment of NSDs, there is a pressing need for further research into non-narrative interventions in that context.

8. Conclusion

The use of narrative has rarely been questioned in dreamwork—even though nightmares and other sleep disturbances are accepted symptoms of common trauma-related conditions such as PTSD. We have argued that this orthodoxy is likely to be based on a number of long-standing but flawed assumptions about the nature of dreams, adopted from a culturally prevalent model of dreaming for which there is surprisingly little support. Dreams are unlikely to be what the standard view of dreaming suggests they are, and this provides warrant to explore alternative models. One alternative (CSM) allows us to challenge a dogma at the centre of discourse around the treatment of dreams: that the treatment of dreams must proceed through the retelling of the dream narrative. We have argued that adopting CSM would in principle increase the range of therapeutic options available for dreamwork. Several factors, including evidence related to increased dropout rates in narrative-focused treatments, suggest there are good practical reasons to explore these alternative options. Despite some promising foundations, the research on non-narrative interventions for NSDs is in its infancy. However, there are solid practical and theoretical grounds for further research into the effectiveness—and comparable 'acceptability'—of such treatments.

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