Archives of Psychiatry and Psychotherapy
Volume 5, Issue 4, December 2003
pages 29–38

Posttraumatic dreams from an analytical perspective

Krzysztof Rutkowski

Department of Social Pathology, Chair of Psychiatry of the Jagiellonian University, Cracow,

Summary: *In the article, the specific character of nightmares, which occur as a direct reaction to trauma, has been described. These nightmares occur in the course of posttraumatic disorders, especially during posttraumatic stress disorder. Analytical perspective has been most widely used, as it considers the importance of nightmares for the dynamics of psychical disorders in the highest degree. Classic interpretations of the origin of specific posttraumatic stress disorder or traumatic neurosis symptoms by S. Freud and C. G. Jung have been described. One can conclude that posttraumatic dreams are distinguished by the following:*

1) content – directly reproducing the trauma,
2) recurring character,
3) bringing out negative emotional reactions, most frequently – anxiety.

Key words: PTSD, dreams, nightmares, Freud, Jung

1. Traumatic neurosis and Posttraumatic Stress Disorder

Since the beginning of modern psychiatry, the problems of the consequences of psychical and physical trauma, their influence on the development of symptoms and specific syndromes of psychical disorders has become the basis of research and numerous attempts to systemize them. For a long time, there was a conviction in medicine that many of, the so-called, 'mental diseases' originate in dramatic experience, the feeling of intensive anxiety, stimuli of the over and above the average strength, or, uncommon suffering.

For the first time, the term 'traumatic neurosis' appeared in Oppeheim's and Charcot's works in 1884. The basic model for studies constituted the cases of hysteria as well as dissociative and converse disorders whose reasons were found in, the so-called, emotional and moral shocks [1]. Only the atrocities of World War I brought the topic of traumatic neurosis back. As a result of research on post-traumatic symptoms, the work "Psycho-Analysis and the War Neuroses" [2] appeared. In the work "Janseits des Lustprinzips" (Beyond the pleasure principle) [3], which was published in 1920, Freud was frequently referring to the subject of post-traumatic neurosis. He directed his attention to basic aetiological factors and to diagnostic criteria. As the first and the

basic one, he distinguished the act of experiencing trauma, At the same time, he emphasized that there did not need to be the direct damage of the central nervous system. He put an emphasis on the patient's reaction with acute anxiety to the stimulus and he defined anxiety as a state which is created in the face of sudden and unexpected danger. Post-traumatic neurosis was to originate as a result of forceful suppression of anti-stimulus protection of a psychical organ which protected the organism against too big a number of stimuli coming from the outside. This protection was weakened by, for example, little aggravation or complete lack of anxiety, namely, the element of surprise and experiencing sudden anxiety because of external danger. Anxiety alertness and psychical tension together with the receptor overloading constituted the protection against stimuli. Furthermore, Freud stressed that patients were characterized by constant and unconscious recurrence to the trauma and re-experiencing it, for example while dreaming, whereas – at the same time and consciously – the patients tried to avoid all topics connected with the traumatic recollections. He assumed that recurrent and unconscious recollections and dreams aimed at producing anxiety and, by this, fixing the 'neglection' from the moment of the trauma origination. Anxiety means here a certain state of danger expectation even if it is unknown and makes the waiting stage easier. Moreover, he drew attention to the fact that the existence of somatic symptoms, for example: pain, counteracted the current origination of post-traumatic neurosis. It seemed to be confirmed in the clinical picture when symptoms of post-traumatic disorders appeared after the stimulus action [3].

Another drama in the history of the human kind, World War II, became the source of considerable increase in the number of post-traumatic disorders. Attempt at systemization of posttraumatic disorders led to the emergence of numerous terms which would describe syndromes of specific symptoms noticed in the most frequently examined population, that is, the population of ex-prisoners of concentration camps. Because of the specific character of the group, the following labels appeared most frequently: progressive asthenia, after-concentration-camp disease, after-concentration-camp asthenia, chronic progressive after-concentration-camp asthenia, KZ-syndrome, after-concentration-camp syndrome and concentration-camp syndrome [4].

Along with the research conducted in Europe, analogous compilations concerning post-traumatic disorders were done in the United States. However, the strongest stimulus for the American authors to continue their research was the return of soldiers after the war in Vietnam. It resulted in the introduction of Post-traumatic Stress Disorder (PTSD) [5]. In the latest fourth edition of DSM [6], diagnostic criteria comprised the following symptoms which were selected as: intrusive distressing recollections of the trauma, avoidance of stimuli associated with the trauma and hyper vigilance. The condition that the manifested symptoms resulted in the breakdown of social functioning was stated. PTSD was placed in DSM-IV in the chapter comprising anxiety disorders. Numerous postulates from medical circles as well as the research results which pointed out to considerable propagation of post-traumatic disorders resulted in introducing – as a separate chapter (F43) to International Statistical Classification of Diseases and Health Problems of the World Health Organisation (ICD-10) [7] – the diagnosis of disorders which developed as a result of the act of trauma. On the other

hand, there appear publications which point to the necessity to widen the diagnosis and the impossibility to describe psychical disorders which occur, for example, in torture victims only by means of PTSD [8]. It is postulated that present criteria of PTSD are insufficient in describing the consequences of the experienced trauma [9]. These discussions resulted in the introduction of the term 'complex PTSD' into unofficial psychiatric diagnostics. The term means a psychiatric syndrome which comprises various symptoms that occur in the reaction to trauma in a higher degree than it was described in PTSD.

2. Definition of post-traumatic reactive nightmares

Having DSM-IV diagnostic criteria as a background [6], one can agree that a nightmare, as a symptom of PTSD, is a recurring and distressing dream of the event of trauma. By this definition, one can exclude the idea that nightmares are symptoms of other complaints and they do not occur as a reaction to the experienced trauma. Such dreams may, for example, accompany the so-called everyday stresses, be a manifestation of other anxiety disorders or intra-psychic situations of the conflict. One can accept the idea of nightmares which recollect the experienced trauma precisely as being in accordance with the condition in the highest degree.

Usually, they are sudden awakenings during sleep with the feeling of fear and anxiety, stimulation of the autonomous nervous system, a strong sense of suffering and fear of re-experiencing the trauma. Recurrent dreams of similar contents and the ones which cause such reactions were described as typical. Thus, nightmares which contain symbolic contents or others which evoke the anxiety were not regarded as symptoms of PTSD.

This approach is in accordance with the traditional and modern ideas about the difference between post-traumatic dreams and others. The classical understanding of dreams, which comprises also the interpretation of their contents, distinguishes the following: dreams contrary to desires, punishing dreams and post-traumatic dreams [10, 11]. Post-traumatic dreams are different from all other types in their role which is to develop anxiety emergency state and controlling the traumatic situation. The starting point of this function unfortunately comes too late: after the trauma. Dreams which do not reflect the trauma may, among all, symbolically depict the traumatic event, however, their role is not to arouse the anxiety emergency but, for example, solutions to intra-psychic conflicts which developed. In research of the survivors of the Holocaust, it is pointed out that post-traumatic dreams occur less frequently in people who were well-adapted to life after trauma. By that, one can understand that the function of post-traumatic dreams fulfilled its task – anxiety emergency state developed and this prevented other symptoms from happening – and recollecting of the traumatic event was not necessary to further controlling of the events [12].

Summing up, nightmares which are symptoms of PTSD are characterized by:

- a recurring character of the dreams,
- dreams about the event of the trauma,
- dreams evoking negative emotional reactions.

In scientific compilations concerning the contents and function of a dream, the dissimilarity of dreams which are, to a considerable degree, just a recollection of the trauma was observed. Those dreams depict indeed autonomous psychic contents, however, even after conscious understanding of their relation to the trauma, there is no visible sign of getting rid of traumatic experience. In dreams, contents which have specific autonomy are still reproduced. As a characteristic feature, the contents and the recurring character of reactive dreams is not disturbed by their analysis, which , according to Jung, may even prove to what a degree can the dream be a post-traumatic dream or is it just a symbolic recollection of a traumatic situation [13]. In this way, dreams which reflect affective experience, trauma, and which have a symbolic meaning are not regarded as post-traumatic dreams. Obviously, it is easy to notice that neither transfer analysis nor active imagining can influence the above-described symptoms. They are a direct consequence of exogenous, sudden trauma which surpasses adaptive abilities. For this reason, they have no symbolic meaning. Jung, ascribed dreams a compensatory function as a basic role though not the only one, Compensatory dreams may comprise contents depicting activities and situations close to the everyday ones. Whereas, specific dreams of exceptional contents, which deeply sink into memory, are usually connected with the process of individuation and comprise archetype contents. They have the origin in 'deeper level' of the unconscious – from the group unconscious [14].

Being interested in the process of individuation, Jung attached considerable importance to the symbolism of dreams and it would be difficult to find citations of real post-traumatic dreams in his works [15]. It is, however, worth drawing the attention to some similarities. Assimilation of the analysis recognized in the process, though hidden behind symbols and dreams contents, seems to have a great importance in the process of psychotherapy. Similarly, the intensification of post-traumatic dreams decreases with assimilation and recognition of traumatic experience. Not until the trauma has been assimilated and included into the consciousness as a life experience together with all its consequences, does the considerable improvement of clinical state happen.

Jung argued with Freud and pointed out that treating the dream function as superior, the function of realizing desires and maintaining dreams, is limited. He himself stressed the compensatory function of dreams against 'a specific consciousness situation' as fundamental. Though Jung did not interpret Freud's views concerning war neurosis and also post-traumatic dreams, his publications confirmed that he had a similar understanding of this symptom. He wrote that 'describing dreams as reductive, prospective or simply compensatory is insufficient in interpreting them. There exists a type of a dream which could be called reactive. One could include into this category all dreams which seem to be nothing else but the reproduction of conscious affective experience, if not for the fact that, thanks to the analysis of dreams of this type, the reason why this experience is reflected in dreams so clearly was found. It turned out that the experience had a symbolic aspect whose existence was overlooked by the individual and only for this reason the experience is reproduced in a dream. However, dreams of this type do not belong to this category; they constitute a group of these dreams in which some objective processes replaced the psychical trauma. This trauma is reflected not only in the psyche – it is equal with physical injury in the

nervous system. Cases of extremely great shock frequently occur during a war: here, one can expect many typical reactive dreams in which traumatic experience is more or less decisive. Through the fact that traumatic contents are frequently experienced, slowly lose their autonomy, in this way, they are once again included into psychical hierarchy and have an undoubtedly big influence for the overall function of the psyche. However, a dream which, to a considerable degree, is only a reflection of trauma cannot certainly be understood as 'compensative'. Such a dream admittedly and visibly shows a separate and autonomous psyche fragment. It turns out however, that conscious assimilation of the reproduced fragment in a dream does not at all result in elimination of a shock determined by trauma. A dream peacefully 'reproduces itself'; this means that the dream contents, which received their autonomy, react themselves until the traumatic stimulus completely ceases to exist. Conscious 'realisation', which was performed before, does not serve anything.'

In this way, dreams which start as a reaction to an experienced trauma do not fulfil a compensative function towards consciousness and do not serve to depict purposeful unconscious impulses. They are a classical example of a co-existence of body and psyche [13]. It is worth noting that general analytical publications usually avoid totally or treat the exceptionality of post-traumatic dreams in short [16, 17].

Dreams reflecting the trauma usually contain a fragment taken from the wider context, a situation when the psychic tension was extremely aggravated; after the very fragment has been presented, they stop abruptly and, in this way, their prospective function proves to be handicapped; i.e. the function which is supposed to show the solution to intra-psychic conflicting contents [18]. Only after the trauma experience has been assimilated, can a dream acquire a symbolic meaning and its contents usually change and then it loses the feature of direct reflection of the trauma with possible existence of negative feelings, anxiety and fear which usually lead to awakening.

Taking the dynamics of the disorder into consideration, it is worth repeating that in psychoanalytical understanding a trauma is described as a fully unexpected event which a particular person is not able to assimilate. A shock is an immediate reaction to trauma and later on spontaneous healing or, as a later effect, the so-called post-traumatic neurosis (PTSD) may occur. It is symptomatic that the traumatic neurosis symptoms are different from symptoms of other disorders by the fact that they are not susceptible to interpretation. So, these symptoms do not have an unconscious meaning but only a function and this seems extremely significant [19]. This makes them different from symptoms of other psychical disorders, especially the functional ones that have an unconscious meaning and function and, as a result, undergo analysis. It obviously directly concerns dreams too. As it is easy to guess, the basic function of post-traumatic disorders will be the assimilation of trauma experience.

The concept that 'recurring dreams represent an effort to deal with the original trauma by means of contradiction' seems surprising. 'Dreams are so realistic that a dreamer is not able to establish their real dream nature at first; so, he may feel that the real event is also nothing else but a dream. Recurrences may serve this aim or vice versa, they may help in establishing the reality of the traumatic event. Patients are

often disoriented in such a moment and the therapist's assurance that the event really did happen may be helpful' [16]. This interpretation is not only far from the classical one but also from the descriptions of complaints which come from the patients who show the direct connection between the dream's contents and the trauma. It is hard to accept such an understanding of the basis of post-traumatic dreams and it seems that such an interpretation would be acceptable only in the case of some strong dissociative disorders. The same authors have claimed that 'post-traumatic neurosis strongly disturbs and it even sometimes disorganizes completely the functioning of a person, however, it easily submits to psychotherapy which allows to understand the disorder on the basic level' [16]. It visibly stands against with statistics which prove the chronic occurrence of post-traumatic disorders [20], which may even lead to a change of personality [7]. This shows that the classical understanding of Freud and Jung, which points to constant recurring of the trauma in order to create anxiety emergency, is more compact and adequate even for present data.

One should take into consideration the possibility of the occurrence of nightmares which are connected with the trauma, however, the patients do not remember dreams. Generally, the reason for forgetting dreams is the accumulation of stimuli after awakening, singleness and uniqueness of dreams, incomprehensibility of their contents, a specific composition which is different from the conscious one [10]. These reasons practically do not fit the definition of post-traumatic dreams. They are usually characterized by a logical composition, analogous to conscious rules of the structure and composition of thought and expression. Their contents are usually repeatable and comprise the same traumatic event which is reflected in a similar way and its recurring course usually aggravates in a stressful situation. The contents are fully identified with authentic events by the patient and they are understood by him. Also, the ability to respond to stimuli which appear after awakening is usually limited; the patients frequently complain about the state of 'alertness, anxiety and stupefaction', sometimes, they complain about momentous and passing problems with orientation in the area and the prolonging feeling the trauma recurrence. Those factors altogether favour the consolidation and remembering the contents of dreams. This constitutes another significant distinguishing feature of post-traumatic dreams. It is worth repeating that both Freud [3] and Jung [13] emphasized the possibility of origination of post-traumatic psychical disorders with no connection with physical damage to the central nervous system.

Dreams have been the subject of study for many years [10]. They have recently lost their popularity in diagnostics to biological methods, but they have still been treated as a respected factor in the psychotherapeutic process [21] for which they have carried considerable informative input [22]. Also, during research on sleeping disorders it has been noted more and more frequently [23] that the overt contents of a dream are connected with other types of sleeping disorders, for example, sleeplessness accompanied by anxiety dreams. In the PTSD diagnosis, dreams are distinguished by direct reflection of the experienced trauma in which the patient took part. This distinguishes them from symbolic contents of everyday dreams. Interpretations of dreams which appear as a response to the experienced trauma point frequently to a compensation or wish-

ful thinking character; this does not refer to dreams which directly reflect the trauma but to dreams which depict a symbolic situation of danger [24]. Nowadays, it is also postulated that some intrusively recurrent symptoms, nightmares including, may be connected with a symbolic expression of negative reactions which are connected with the experienced trauma [25]. Epidemiological research confirms frequent occurrence of dreams with the contents connected with the trauma in the course of post-traumatic syndromes [26, 27]. In the research, a group of patients with symptoms of anxiety syndromes, who were not affected by the trauma - a changeable frequency of nightmare occurrence was proved; in that case, however, dreams play a symbolic role and their occurrence may depend on an individual course of the anxiety syndrome [28]. At the same time, attention is drawn to the fact that symbolic contents of a nightmare which occurs after the trauma may be connected with a strong feeling of guilt [29] and the involvement of the dissociative mechanism [30]. This fact may suggest a more frequent conscious occurrence of nightmares and dissociative symptoms in the course of PTSD, especially when the anxiety is experienced as a reaction to the feeling of guilt or shame. On the basis of this information, one may suspect that such reactions may be more frequent with people who experienced sexual trauma, for example, they were the only survivors [the so-called survivor syndrome]. It was also proved that the direct and overt contents of dreams might play a significant role in the diagnosis of post-traumatic disorders. The occurrence of dreams with the contents associated with the trauma point to the anxiety course of PTSD, and their lack points to the aggravation of the depression course [31]. It was also proved that experiencing anxiety regardless of the reason for its origination considerably worsened the course of a night dream, independently even of the contents of dreams. Anxiety, next to somatic pain, is the most common reason for problems in falling asleep and staying asleep; such a co-relation has not been found for the symptoms of depressive disorders [32].

3. Specific clinical research

The research was carried in the Department of Social Pathology at the Chair of Psychiatry of the Jagiellonian University. Detailed results have been published in Archives [33] and as a book [31].

90 people, who were persecuted and tortured for political reasons in Poland in 1944–1956, were diagnosed with clinically recognised PTSD.

People, in whom one of PTSD symptoms is the recurrence of dreams with the contents directly connected with the trauma, are characterised by:

- High level of general anxiety,
- Tendency to react with anxiety to new situations,
- Similar level of momentous anxiety and anxiety as a permanent personality feature,
- Considerable feeling of suffering, low self-esteem with other accompanying subjective symptoms concerning negative evaluation of oneself, the surrounding and time,
- A relatively low level of objective and clinical depression symptoms,

- Higher aggravation of PTSD with a considerably more frequent mild aggravation of symptoms.

People with diagnosed PTSD, who do not remember nightmares are characterised by:

- High level of general anxiety,
- Higher level of anxiety as a permanent personality feature than momentous anxiety,
- Low self-esteem, high feeling of suffering and the occurrence of other subjective symptoms of negative evaluation of oneself, the surrounding and time,
- High level of objective depression symptoms,
- Mild course of PTSD.

A subjective symptom, which is the contents of dreams, indicates PTSD. Nightmares with the contents directly connected with the trauma occur in people with more strongly visible anxiety symptoms; this symptom does not occur in people with the aggravation of depression symptoms.

The results are in accordance with previous experiences and models of the origination of PTSD symptoms. They refer to all groups of victims in which there is suspicion of the occurrence of post-traumatic reactions.

4. Summary

Post-traumatic dreams:

- Have the contents directly connected with the experienced trauma,
- are frequently recurrent,
- and, evoke negative emotional reactions.

Easiness in remembering is a distinguishing feature of dreams. This definition is in accordance with Freudian and Jungian theories concerning dreams. They proved that post-traumatic dreams do not play a role in realising unconscious wishes, they do not keep the dream and they do not have the compensation function towards consciousness. It seems that the theory which states that one must re-experience the trauma in order to evoke anxiety alertness and, further on, the assimilation of the experience of the trauma is most cohesive and still up-to-date. Clinical research proves this; it shows that people with post-traumatic disorders and nightmares have a slightly different profile of symptoms than people who experienced the trauma but they do not suffer from recurrent post-traumatic nightmares. The lack of nightmares is connected with more visible depression symptoms; this may also point to a depression reaction to the assimilated trauma. People who are characterised by the occurrence of recurrent nightmares usually have all the symptoms of post-traumatic disorders with a typical anxiety symptoms profile. Obviously, recurrent dreams could indicate the on-going process of trauma assimilation. PTSD can be interpreted as a symptom of the process of adaptation. A continuing recurrence of the trauma situation (for instance, in dreams), whose aim is the adaptation of the person to situations after experiencing the trauma,

is the picture of the dynamics. A positive picture of the process finalizing will be the recession of all symptoms of PTSD accompanied by the shapening of the correct and mature personality.

References

1. Crocq L. *Oppenheim, Charcot, Janet, Breuer, Freud, Jean Crocq and others. Around the year 1889.*, Fourth European Conference on Traumatic Stress, Paris - France, 7-11.05.1995. Book of Abstracts, Paris 1995, 31.
2. Ferenczi S, Abraham K, Simmel E, Jones E, Freud S. *Psycho-Analysis and the War Neuroses,* The International Psycho-Analytical Press, London, 1921.
3. Freud S. *Poza zasadą przyjemności.* Wydawnictwo Naukowe PWN, Warszawa 1994: 7–58.
4. Kłodziński S. *Swoisty stan chorobowy po przebyciu obozów hitlerowskich.* Przegląd lekarski – Oświęcim, 1972; 1: 15–21.
5. (DSM-III) Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. American Psychiatric Assiciation. Washington D.C., 1980.
6. (DSM-IV) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. American Psychiatric Assiciation. Washington D.C., 1994.
7. (ICD-10) Międzynarodowa Statystyczna Klasyfikacja Chorób i Problemów Zdrowotnych – rewizja 10, rozdział V. World Health Organization. Vesalius, Kraków, 1994.
8. Somnier F, Vesti P, Kastrup M, Genefke I. *Psychosocial consequences of torture: current knowledge and evidence.* in: Basogliu M. *Torture and its Consequences.* Cambridge University Press, 1993: 56–71.
9. Jongedijk RA, Carlier IV, Schreuder BJ, Gersons BP. *Complex posttraumatic stress disorder: an exploratory investigation of PTSD and DES NOS among Dutch war veterans.* J-Trauma-Stress, 1996; 3(9): 577–586.
10. Freud S. *Objaśnianie marzeń sennych.* Wydawnictwo KR, Warszawa, 1996.
11. Vedfelt O. *Wymiary snów. Istota, funkcje i znaczenie marzeń sennych.* Wydawnictwo Psychologii i Kultury Eneteia, Warszawa, 1998.
12. Lavie P, Kaminer H. *Dreams that poison sleep: Dreaming in Holocaust survivors. Dreaming,* 1991; 1: 11–21.
13. Jung CG. *Ogólne uwagi na temat psychologii snu.* in: *O istocie snów.* Wydawnictwo KR – Wydawnictwo Sen, Warszawa, 1993. (CW VIII).
14. Jung CG. *O istocie snów.* in: *O istocie snów.* Wydawnictwo KR – Wydawnictwo Sen, Warszawa, 1993. (CW VIII).
15. Jung CG. *Praktyczne zastosowanie analizy snów.* in: *O istocie snów.* Wydawnictwo KR – Wydawnictwo Sen, Warszawa, 1993. (CW XVI).
16. Moore BE, Fine BD. *Słownik psychoanalizy.* Jacek Santorski & Co., Warszawa, 1996.
17. Samuels A, Shorter B, Plaut F. *Krytyczny słownik analizy jungowskiej.* UNUS, Warszawa, 1994.
18. von Franz M-L. *Ścieżki snów.* Jacek Santorski & Co. Agencja Wydawnicza, Warszawa, 1995.
19. Rycroft C. *Dictionary of Psychoanalysis.* Penguin Books, London, 1972.
20. Kaplan H, Sadock B. *Psychiatria kliniczna.* Urban & Partner, Wrocław, 1995.
21. Cartwright RD. *Who needs their dreams? The usefulness of dreams in psychotherapy.* J-Am-Acad-Psychoanal, 1993; 4(21): 539–547.
22. Abramovitch H. The nightmare of returning home: a case of acute onset nightmare disorder treated by lucid dreaming. Isr-J-Psychiatry-Relat-Sci, 1995; 2 (32): 140–145.
23. Schredl M, Kraft B, Morlock M, Bozzer A. *Dream contents of sleep disordered patients.* Psy-

chotherapie, Psychosomatik, Medizinische Psychologie, 1998; 2 (48): 39–45.

24. Susułowska M. *Próba interpretacji treści snów byłych więźniów obozów koncentracyjnych.* Przegląd lekarski – Oświęcim. 1976; 1: 13–17.
25. Inderbitzin LB, Levy ST. *Repetition compulsion revisited: implications for technique.* Psychoanalytic Quarterly, 1998; 1(67): 32–53.
26. Hudson JI, Manoach DS, Sabo AN, Sternbach SE. *Recurrent nightmares in posttraumatic stress disorder: association with sleep paralysis, hypnopompic hallucinations, and REM sleep.* J-Nerv-Ment-Dis, 1991; 9(179): 572–573.
27. Jagoda Z, Kłodziński S, Masłowski J. *Sny więźniów obozu oświęcimskiego.* Przegląd lekarski – Oświęcim, 1977; 1: 28–65.
28. Wood JM, Bootzin RR. *The prevalence of nightmares and their independence from anxiety.* J-Abnorm-Psychol., 1990; 1(99): 64–68.
29. Lansky MR. *The transformation of affect in posttraumatic nightmares.* Bull-Menninger-Clin, 1991; 4(55): 470–490.
30. Stevenson DV. *The analysis of an adult with night terror.* Psychoanal-Q, 1991; 4(60): 607–627.
31. Rutkowski K. *Zaburzenia snu w zespole stresu pourazowego.* Wydawnictwo Oddziału Polskiej Akademii Nauk w Krakowie. Kraków, 2001.
32. Moffitt PF, Kalucy EC, Kalucy RS, Baum FE, Cooke RD. *Sleep difficulties, pain and other correlates.* J-Intern-Med, 1991; 3(230): 245–249.
33. Rutkowski K. *Anxiety, depression and nightmares in PTSD.* Archives of Psychiatry and Psychotherapy. 2001; 2: 41–50.

Author's address:
Katedra Psychiatrii CM UJ
Zakład Patologii Społecznej
ul. Kopernika 21
31-501 Kraków, Poland
phone (+48 12) 4248737