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Communication about nightmares

A phenomenological study into the lived experiences of patients with PTSD

1 | Introduction

Nightmares are reported by 50-70% of people with post-traumatic stress syndrome (PTSD) (Spoormaker, Schredl & van den Bout, 2006; Levin & Nielsen, 2007; Swart, van Schagen, Lancee, & van den Bout, 2013). Nightmares bring traumatic and intrusive memories to mind (Spoormaker & Montgomery, 2008), with detrimental effects on one's functioning and quality of life: PTSD-patients with posttraumatic nightmares have more severe complaints than patients who not suffer from these nightmares (Schreuder, Van Egmond, Kleijn, & Visser, 1998). A study on nightmares and suicide in PSF found that nightmares were both directly and indirectly associated with suicidal behaviors (Littlewood, Gooding, Panagioti & Kyle, 2016). Nightmares seriously disrupt sleep (Krakow, Tandberg & Scriggins, 1995), affect psychological, social and somatic wellbeing and undermine daytime functioning (Krakow, 2006; Nielsen & Levin, 2007). Furthermore, nightmares increase vulnerability for stressful stimuli (Hochard, Heym& Townsend, 2016) and relapses into PTSD and other psychiatric disorders (Phelps, Creamer, Hopwood & Forbes, 2014; Nadorff, Nadorff & Germain, 2015).
Various theories address the possible underlying pathogenetic, emotional and cognitive dynamics behind nightmares that may also influence communication. Avoidance of post-trauma-related stimuli reduces anxiety temporarily, but reinforces avoidance, after which corrective emotional experiences fail to occur (Foa & Kozak, 1986). Spoormaker introduced a cognitive model in which the storyline of recurrent nightmares is represented as a disturbing, repetitive memory script that cannot be altered because of cognitive avoidance due to negative appraisals/self-beliefs and nightmare distress (2008). Levin and Nielsen's neurocognitive model proposes that nightmares reflect failed emotion regulation, and occur as a result of affect load

(emotional pressures) and affect distress, whereby events are experienced with high negative emotional reactivity (2007, 2009).

People with PTSD seem to communicate minimally about their nightmares. Consequently, nightmares – despite their adverse effects – often remain underexposed. This study concerns manners in which people with PTSD communicate about their nightmares. A prior literature search found no specific research on this topic. A study by Swart *et al.* (2013) in psychiatric outpatients found that 30% of the studied population had an undiagnosed nightmare disorder (APA, 2013). Apart from diagnostical aspects, the presence of this disorder may have to do with the way in which people with PTSD patients do or do not communicate about nightmares. Seeing that experiences acquire meaning through the process of communication (Holstein & Gubrium, 1994), research into communication on nightmares within a PTSD population can increase insight into a) the ways people communicate about their nightmares and give meaning to these experiences, and b) the phenomena that influence communication on nightmares. These phenomenological insights can have implications for nightmare treatment and recovery.

Research in general and psychiatric populations has revealed that personality traits and coping mechanisms in dealing with nightmares or PTSD affect the way in which one communicates one's nightmares. For example, Schredl & Göritz (2014) researched *coping strategies for nightmares in the general population* and found that 'sharing-communicating' was the most common coping strategy, followed by 'rescripting-lucid dreaming' and 'reading about it'. Only 6.91% of people suffering from nightmares sought professional help; in two-thirds of cases, this had no result.

Research on *coping with nightmare frequency* observed tendencies to emotion-oriented coping in both general populations (Köthe, Lahl & Pietrowsky, 2006) and in psychiatric populations (Van Schagen, Lancee, Swart, Spoormaker & Bout, 2016). Emotion-oriented coping aims to minimize distress, through self-soothing, expressing negative emotions, rumination and avoidance/denial (Carver & Connor-Smith, 2010). Executive and cognitive functions simultaneously decrease when emotional distress increases (Simor, Pajkossy, Horváth & Bódizs, 2012).

Köthe & Pietrowsky (2001) found significant correlations between *personality variables and (behavioural) consequences of a nightmare*, such as physical complaints, negative emotions, and dysfunctional cognitions. Study participants who scored high on 'neuroticism', 'stress', and 'were not satisfied about their lives', were heavily influenced by nightmares.

This study *aims* to gain insights into the lived experiences of a sample of people with PTSD with regard to communication about nightmares. These insights can help explore and enrich the possibilities for professional connection to nightmare-related problems. This study will therefore address the following *research question*: What are the lived experiences of people with PTSD with regard to their communication about nightmares?

2 | Method

2.1 | Study design and sample

Colaizzi's strategy of descriptive phenomenological analysis was used (Polit & Beck, 2012; Shosha, 2012; Morrow, Rodriguez & King, 2015). Phenomenological research aims to uncover and understand the lived experiences of the participants in their daily environments (Polit & Beck, 2012; Van der Meide, 2015). Experiences acquire meaning through the process of communication. This qualitative research design is conducted within the constructivist paradigm, which assumes that there is no fixed objective reality (Mortelmans, 2018).

This interview study was conducted in a Dutch mental health institution specialised in the treatment of psychotrauma for outpatients with complex PTSD and/or complex trauma. Throughout the Netherlands, this institution is recognized as a centre of excellence.

The target population consisted of outpatients with PTSD (according to the DSM-5 criteria) who experienced frequent nightmares. Eligible for participation were those aged between 18-65 years old who had at least two nightmares monthly. Those with insufficient command of the English or Dutch language were excluded.

To ensure rich data collection, and to derive common themes despite diversity, we used purposive sampling to select participants, pursuing maximum variation regarding gender, age, and social/cultural backgrounds (Polit & Beck, 2012).

2.2 | Data collection and analysis

All three psychotrauma teams operating within the institution were informed about the study verbally and in writing. In collaboration with the healthcare professionals of these teams, fourteen outpatients were invited to participate. All received verbal and written information about the qualitative study before being interviewed, and could ask questions. Open, in-depth interviews, for which participants had provided informed consent, were held between September 2019 and March 2020 at the participants' preferred location, so that they would feel at ease (Polit & Beck, 2012). Ten interviews took place at the outpatient clinic and three in the home situation. One interview took

place by telephone, because the interviewee had been relocated to an asylum centre at great distance.
During interview preparation, background data on social and cultural backgrounds, trauma, treatment, religion, and nightmare duration and frequency were collected from patients' records (Mortelmans, 2018). In line with methods of phenomenological research, literature-based topic lists on coping mechanisms for nightmares and personality traits within PTSD and/or nightmares were used only as 'aides-mémoires' (Burgess, 1984).
To obtain as full as possible understanding of a participant's lived experiences, the interview style was interactive, non-directive, flexible and face-to-face. The researcher adopted active listening and focussed on the participant's stories and experiences, assuming an open and respectful attitude (Mortelmans, 2018). Furthermore, the interviewer's attitude was imaginative and empathetic, whereby her own assumptions and interpretations were set aside, i.e. bracketing (Ashworth& Lucas, 2000). A reflexive log was kept to critically reflect on personal experiences, biases and preconceptions (Gearing, 2004; Ahern, 1999).
Three pilot-interviews had been performed with two experienced colleagues (MANP, clinical psychologist) from the Psychotrauma department and with the research supervisor. These pilot-interviews had been conducted to assure methodological quality; develop interview skills and sensitivity around the research theme.
Interviews were audiotaped and transcribed verbatim. Notes made during the interviewswere recorded in a log. Data were organized in MAXQDA (Kuckartz & Radiker, 2019). After the first five interviews, an initial analysis was performed on arising phenomenological themes. The interim analyses of data collection and data-analysis steered subsequent data collection in an iterative process (Van der Velde, Jansen, Dikkers, 2018; Bryman, 2012).
Via peer-debriefings, the quality of the data collection and analytical process was assured. Various aspects of the study were explored and assessed with independent colleagues.. To discuss the progress of the research, the research supervisor and researcher met after the pilot-interviews, first, fifth, and tenth interviews. They assessed and analysed the transcripts of the first, fifth and tenth interviews.
According to Colaizzi's strategy, 1) Transcripts were read and re-read to obtain a general sense of the interview content; 2) Significant statements about nightmare communication were extracted and coded; 3) Transcripts were coded and categorised into meaningful themes; 4) Meaningful themes were integrated and coded into theme-clusters; 5) Results were defined and integrated in a cohesive description of the phenomena; 6) Results were described in the fundamental phenomenological structure as thoroughly and unambiguously as pos-

sible. 7) To validate the results, participants were asked to give feedback on the descriptive results.. Three participants indeed provided feedback, and reported that they recognized themselves in many of the various results, and that this made them better understand their negative emotions/beliefs.

2.3 | Ethics

The Scientific and Ethics Committee of the participating mental health institution reviewed and approved the research. Only the researcher and supervisor had access to the research data, audiotapes and transcripts. To reduce the burden on participants, interviews were performed only once, and lasted about one hour.
Participants received a 25-euro gift-voucher post-interview.

3 | Results

The sample consisted of 14 outpatients, nine women and five men. Their mean age was 40 years (range 30-54 years). At the time of the interview, eleven of them were in a PTSD-treatment trajectory, and three patients were on a waiting list for treatment.
All participants had suffered from severe nightmares for years. The mean duration of nightmare complaints was 22 years (range 5-40 years). Nightmare-frequency varied from at least 2-3 times monthly to 5 times nightly.
Backgrounds differed on trauma, nationalities, status and religion (table 1).
On the basis of the analysis of the interviews, we categorized the experiences about post-traumatic nightmare communication were categorized into four main themes, summarized in table 2.

3.1 | In general

Participants re-experienced their traumas in nightmares. All participants recognized themselves in the detrimental effects of their posttraumatic nightmares, as described in the introduction. These adverse effects had a significant impact on their daily functioning. Nightmares caused hyperarousal and hypervigilance, and at a deeper level constantly caused a sense of being unsafe.
The coping strategy with nightmares generally was avoidant: wanting and trying not to think about it, looking for distraction, not wanting to burden others, and maladaptive coping like numbing feelings, memories, and thoughts with alcohol or drugs, suicidal thoughts or self-harm. Several participants were afraid to talk about the trauma, lest the nightmares should occur more often.

Table 1
Backgrounds

Gender	Female	9
	Male	5
Nationality	Dutch-Surinamese	3
	Dutch	3
	Dutch-Curaçaoan	1
	Gambian	1
	Jamaican	1
	Moroccan	1
	Nigerian	1
	Polish	1
	Sierra Leonese	1
	Somalian	1
Status	Immigrant	5
	Dutch resident	3
	Not documented	3
	Refugee	2
	Asylum applicant	1
Trauma	Sexual abuse childhood/violence/neglect	6
	Sexual abuse adulthood/violence/human trafficking	3
	War violence/military deployment	3
	Domestic violence childhood/neglect	2
Religion	Hindu	3
	Muslim	3
	Christian/Pentecostal	2/2
	Non-religious	4

Table 2
Themes

In general	Detrimental effects Avoidance
Trust	Trust in others Trust oneself
Responsiveness	Non-responsiveness Responsiveness
Experiences with healthcare workers	Trust Non-responsiveness Responsiveness/recovery

"To be honest, I don't want to talk about rape either. Because when I talk about the rape, I have nightmares at night." (P-10)

As such, participants did not or hardly talk about their nightmares outside the context of treatment. Not all patients report their nightmares during treatment, as discussed in 3.3.

"I'm just avoiding them, those nightmares." (P-1)

"No, I don't talk to people about it, because then you experience it again. And I try as best I can to forget it." (P-9)

3.2 | Trust

Lack of trust in others and oneself was a recurring phenomenological theme in the avoidance of communication about nightmares. Trust in others and in oneself were inextricably linked. The threats and harm experienced in previous traumas, affected participants' *trust in others*. The traumatic experiences eroded participants' integrity and identity: *trust in oneself* was compromised. In the past, essential caregivers often had often contributed to the experience of trauma (i.e. as offenders). Several participants stated that loved ones refused to see what took place; they did not recognize the person's needs, fuelling distrust and negative emotions towards themselves and beliefs about themselves. Due to the lack of commitment and attention, participants experienced neglect, leading to feelings of inferiority and a deep sense of irrelevance. In essence, the participants felt existentially abandoned by those who should care for them, and on whom they should be able to rely.

"By my parents and by my siblings..., I was already ignored anyway. I didn't actually exist. I didn't exist for anyone.... No..., literally nobody cared about me, really". (P-4)

"I feel ashamed... I'm not the same as other people ...I always feel 'small', not on the same level as other people. Of less value..., no value...." (P-10)

After opening up about their nightmares or traumas, some participants were accused or held liable for their part in the trauma. Such disloyalty increased participants' mistrust, reinforced feelings of abandonment by loved ones, and contributed to social exclusion. This deepened the idea of being an outsider: they did not dare to share anything.

"A few times they said: 'It's your fault'... I don't trust any man." (P-9)

"African people judge... You become an outsider... It's very hard to talk about it...." (P-6)

Nevertheless, several participants mentioned at some point the need to talk about their nightmares. They hoped to find relief or support, but instead they often encountered denial, disbelief, judgments, or trivialization. As a result, damaged trust deepened feelings of insecurity and self-doubt. The idea that nobody could be confided in grew. Participants withdrew from communication furthermore,

which made them more dependent on themselves; feelings of loneliness and despair enlarged, and social isolation increased. In a way, damaged trust traumatized them on a social level. These experiences affected communication in the past and at the time of interviewing. They dared not trust anyone, even if they had reliable partners/friends.

"Yes, in my youth, of course, I tried to talk about my nightmares... Later on, I tried it here with an aunt of mine, but according to her, it is all in my head... And so then... yes, then you'd rather not talk about it...I don't trust anyone anymore." (P-7)

Based on former traumatic experiences, *trust in oneself* was compromised. Participants experienced low self-esteem and doubted themselves. As a result, they stopped communicating about themselves, or about what was going on with them. With that, the authentic expression of their emotions, thoughts got lost. This maintained self-doubt and led to internal and external disconnectedness and detachment.

"I don't try to get attached to people because I'm afraid of being disappointed. I won't be attached to others anymore, because I'm scared of losing." (P-7)

As a result, participants did not trust that it was okay to *be* themselves. Various participants stated that they did not feel the urge to express themselves, and instead presented themselves very differently outwardly. They described a pattern of comporting themselves better to the outside world, while in their inner world they felt torn apart by negative emotions and beliefs. This exhausted them. They lost the connection with themselves.

"Until you close the door and go about from your home, you're totally someone else. I was like... an actor. I got a second role in my life: to be a happy girl". (P-14)

"I fake all the time. I hide everything." (P-2)

Participants tried to communicate about their nightmares/traumas with people in their vicinity. They spoke to siblings, parents, friends, religious leaders. Some participants mentioned positive experiences that contributed partly to the restoration of trust. It was helpful if loved ones were understanding. But it was striking that most participants did not dare to tell anyone the whole story outside of treatment. Participants stated that these reservations were based on previous experiences.

3.3 | Responsiveness/non-responsiveness

Non-responsiveness after sharing nightmares/traumas confirmed participants' ideas that it was not safe to share. Several participants stated that at some point they disclosed about their nightmares/trauma. Instead of needed understanding, validation and support, they experienced *non-responsive* reactions, such as disbelief: *"Next time*

you're afraid people won't believe you. So, you don't talk about it anymore" (P-6); denial: *"And he said: 'I don't believe it!'."*; condemnation: *"It is your own fault"* (P-9); trivialization: *"Aah dude, that happened, we'll get over it'"* (P-3); coverage/taboo: *"Despite you experienced the greatest misery together, talking about is still a taboo"* (P-3).

Various participants stated their earliest trust-eroding, non-responsive experiences with self-disclosure often had a *cultural background*. Negative experiences were gained in participants' *family cultures or households*, such as: low family cohesion; no affective involvement; lack of communication and trust due to sexual violence/conflicts within the family; being under forced silence by violent offenders.

"I lived with nightmares, and I lived in a nightmare." (P-11)

"It wasn't allowed to tell anyone about what went wrong at home." (P-12)

Participants stated a judgmental, cultural expression of religion increased their fright and self-doubt; openness was hindered.

"Nightmare is an expression of evil/the devil." (P-6/8/13)

"Sometimes you're accused: 'You're possessed, a witch'." (P-6)

Referring to their *cultural contexts*, participants described gossiping and disqualification as a source of unsafety and non-responsiveness within the Somalian, Moroccan, Surinam and Jamaican cultures: *"They'll say I'm crazy, if they know what's going on."* (P-5) Also lack of knowledge about psychiatry and psychiatric disorders within the originating country was experienced, as a result of which the complaints were not properly responded to.

In a *military work setting*, open sharing and self-disclosure was reported as deviant, partly because of the prevalent macho culture, partly because of the deep-rooted military code of secrecy, because sharing information could be dangerous.

"You don't talk about your feelings: 'Just shut up and don't whine like that'." (P-3)

Non-responsiveness reinforced *distrust* and the learned *negative emotions and beliefs* about oneself. Participants stated that nightmares constantly actualized a variety of *negative emotions* (fright, panic, anger, guilt, shame, sadness, despair and loneliness), and *negative beliefs* about themselves. 'Being inferior', 'being not worthwhile and rejected' became automatic responses within self-blame, self-condemnation, self-doubt. Participants constantly tried to conceal or cover up negative emotions and feelings. By internalizing negative beliefs and emotions, participants confirmed their negative assumptions about themselves within *non-responsive self-dialogue*. Within self-dialogue, participants especially experienced feelings of shame and guilt about the traumas, which infringed their *integrity and identity*. Most participants blamed, criticized and censored themselves constantly, which increased internal as well as external disconnectedness.

"I didn't feel any connection at all, I just felt very, very alone". (P-12)
Several participants stated that rationally they could believe that 'they were not to blame', but this was not felt at an emotional level. Alleged guilt increased shame, self-blame and self-doubt, which isolated them from communicating about their nightmares/traumas.
"I'm afraid to tell other people what I've done. I'm afraid people will distance themselves from me, because of what I've done, seeing me as a bad person. But it's better to be alone, because no one can hurt me, and I can't hurt anyone." (P-2)
"*One of the things my mother always made very clear was that it was my fault that this happened... I can hardly let go of this."* (P-12)
"Blaming myself is the only way that I know..., it's an automatic response." (P-11)
"Yes, I am very ashamed to admit that my parents ... beat me ... so much." (P-10)
The fear of self-disclosure was major, based on the idea that one would be judged and no longer be seen as one was now. A former child soldier stated:
"I'm afraid people will distance themselves if they know what I've done, seeing me as a bad person". (P-2)

A number of participants, however, communicated about their nightmares in a *self-responsive way*. Three participants wrote about their nightmares, for various reasons: being able to express oneself; being able to entrust oneself; writing off in order to function during daytime; wanting to understand the larger context.
"Talking about nightmares with god, angels" during prayer was more often experienced as relief and support, because no disproof/judgment was given, resulting in safety. Two participants stated that in these 'conversations' they could be who they really were. Another participant stated that she experienced trustworthy support from god.
"Yes, that you're closer to God and that he is the only one who can help you." (P-13)
From a non-judgmental perspective, a number of participants found safety and comfort in their nightmare communication with pets.
Two participants made drawings about their nightmares and early childhood traumas. One participant drew between the ages of 12 and 16, because she felt blocked if she wanted to share her nightmares, and could express herself better by drawing. The other participant had started drawing before therapy for her PTSD. She wanted to show her drawings to friends, so they would know and understand what was going on. In drawings, something could be expressed for which there were not, or not yet words, or which they did not dare to put into words.

3.4 | Experiences with healthcare workers

Participants experienced both responsive and non-responsive communication with different healthcare workers. They usually indicated that they had their first responsive experiences when discussing trauma/nightmares within specialised therapy. The responsive approach of therapists contributed to a tentative restoration of confidence, and willingness to disclose. This contributed to rehabilitation and recovery experiences.

Empowered by positive therapy experiences, a number of participants reported feeling acknowledged, learning about their feelings/thoughts, better understanding their needs, and becoming more assertive about what they needed. Participants felt encouraged to practice these insights in their daily lives. Simultaneously, however, this created ambivalence towards openness, because their low confidence (in themselves and others) was more deeply ingrained.

Participants stated that a number of factors contributed to safety and trust within the therapeutic relationship: professional secrecy; respect; sincere involvement/paying attention; empathy/validation; giving context and coherence to what participants had experienced; being non-judgmental; being taken seriously/thinking along, and sometimes making an extra effort for the patient; normalization; letting the patient maintain control; reassurance and encouragement to communicate and to follow therapy by not avoiding (sometimes being firm) and asking questions about traumas; psychoeducation about PTSD and its consequences. Expertise was often stated as a decisive factor.

"Confidentiality, no judgements... It made me feel safe... They helped me overcoming shame. I communicate better with myself... And I learned it's normal to share with friends." (P-11)

"Their expertise gives you confidence and then you'll automatically tell." (P-13)

"They encouraged me to talk about it, despite my shame." (P-2)

Perceived uncertainty and lack of expertise on the part of the therapist elicited distrust in participants. Participants also became distrustful and withdrew from communication when they were required to change therapist, or if healthcare workers made inaccurate statements: connection was compromised, and therapy stagnated.

"Oh, I've never heard such a story". (P-1)

Strikingly, participants indicated that they rarely initiated communication on nightmares during treatment (despite experiencing distress). On the one hand, participants stated that the nightmares had often existed for a long time and felt like a normal part of their lives; therefore, it did not occur to them to discuss them.

"I have them from an early age, they're just there". (P-12)

"I don't feel I can do anything about it." (P-6/P-11)

"For the first 30 years, I wasn't aware that I might be able to influence my nightmares. I tolerated them." (P-8)
On the other hand, participants wished to avoid thinking or talking about their nightmares as a coping mechanism. Sometimes, practitioners asked little about nightmares. According to some participants, this was related to the focal treatment (imaginal exposure, EMDR) they received, which meant that sometimes there was not enough opportunity to reflect on adjacent problems.
Some participants stated that they would like to receive more information about nightmares within the treatment trajectory, so that one could to develop an alternative perspective on nightmares than culturally acquired.

4 | Discussion

This study aimed to gain insight into how people with PTSD communicate about their nightmares, and how they give meaning to their experiences with communication about nightmares. The qualitative interviews provide insight into how people with PTSD and nightmares give meaning to their interpersonal trauma, and how various resulting phenomena influence the way they communicate about their nightmares.
The interpersonal harm that the participants experience compromises their confidence in others and oneself. Trust is an essential condition for open communication. In all the cases of this study, confidence is affected by emotional non-responsiveness in others. Subsequently, within self-dialogue, negative emotions such as anger, guilt and shame interrelate with negative thoughts about oneself (inferiority, worthlessness, meaninglessness, futility), inducing self-critical and negative self-beliefs (abandonment, self-doubt, self-judgment, low self-esteem), and resulting in social isolation. These combined phenomena alienate them from themselves and others. As communication about their nightmares/traumas stagnates, the possibility for them to change their perspectives is taken away, which contributes to maintaining the PTSD-complaints/nightmares.
Whereas PTSD used to be regarded a predominantly anxiety-based disorder, the DSM-5 (2013) highlights PTSD-criteria such as negative self-directed emotions and beliefs. Guilt and shame are *social and moral emotions* that incite self-criticism, self-judgment, self-blame, and therefore strongly incite withdrawal from communication and social interaction. Taylor (2015) suggests in her review that posttraumatic shame and maladaptive shame regulation strategies may play an important role in the maintenance of PTSD-symptoms. Recently, Tran and Beck (2019) have shown that negative beliefs about the self

– self-blame; guilt; and shame; as well as negative self-conscious beliefs – are associated with all PTSD-symptoms.
In this study, the participants experienced particularly guilt and shame as negative emotions. Badour, Resnick & Kilpatrick (2017) have shown that shame within interpersonal trauma/assault-related PTSD is uniquely associated with PTSD (as well as anger and fear). While guilt refers to an action, shame refers to the *person*; this makes an ashamed person feel unworthy, dirty, hideous and impure (Prinz, 2013, p.103). If moral beliefs have been violated, *moral injury* hinders psychological recovery. Within this concept, which has emerged from research on military violence (Litz *et al.*, 2009), attention is paid to shame. Similar to moral injury, most of the participants in this study felt burdened by feelings of guilt, shame, meaninglessness and worthlessness, which makes moral injury an interesting concept for emotional/moral damage experienced within assault-related PTSD/ interpersonal trauma. Self-compassion can be learned as a positive self-response to shame. Self-compassion appears to be positively associated with resilience and negatively with emotional dysregulation and PTSD-symptoms (Scoglio *et al.*, 2015).
This study also shows that the earliest negative responses to nightmare communication and emotional needs are often culturally determined. Variations in cultural beliefs influence patients' beliefs/ meanings (Schnyder *et al.*, 2016). This also appears to be the case with negative beliefs/meanings regarding PTSD/nightmares, which can contribute to the withdrawal from communication. Due to the increasing cultural diversity in our society, culture-sensitivity within treatment is imperative. Culture-sensitivity mainly requires skills such as the ability to distance oneself from obviousness, putting one's own frame of reference into perspective, and being open to the culture of the person (Knipscheer, Drogendijk & Mooren, 2011).
Given the high prevalence of nightmares in relation to PTSD, the finding that participants in this study hardly talk about their nightmares, as well as the finding from an earlier study that 30-50% of PTSD-patients retained symptoms after validated treatments (Bradley, Greene, Russ, Dutra & Westen, 2005), further research into nightmares, PTSD and its associations with negative self-conscious appraisals/emotions is to give insights in the phenomenology of social isolation and withdrawal from communication.
Focal treatment of PTSD-complaints and nightmares offers perspective, but treatment is often difficult and not always successful. Research into impeding and intersecting factors within communication, such as negative emotions (specifically shame, guilt and anger) and beliefs, and into possible relationships with complex PTSD and/or complex trauma can provide new insights into treatment options.

4.1 | Strengths and limitations

One of the strengths of this study is the heterogeneous sample. Future research focussing on specific groups (sexual trauma) or (cultural), gender aspects could provide more insight into underlying emotions and beliefs within communication about nightmares/traumas, which can provide new insights and input for treatment.
Another strength is that the study obtained an in-depth understanding of the lived experiences of communication on nightmares, by drawing on appropriate research methods during data-collection and analysis – with thick-descriptions and thick-interpretation (Ponterotto, 2006).
A limitation of this study is that discussion about nightmare communication during the interviews often intertwined with discussion on the trauma that the nightmare was based on. However, because nightmares are intrusive re-experiences within PTSD, possible entanglement must be taken into account when one wishes to understand communication on nightmares.

4.2 | Practice implications

Given the findings of this study, professional care within PTSD-treatment needs to focus on various aspects that can contribute to emotional responsiveness, recognition, self-compassion, and rehabilitation:

1. Psychoeducation, actively asking about nightmares, exploring the contributed meaning/emotions/beliefs to nightmares, and discussing it within a culture-sensitive, non-judgmental, attentive, reliable, professional attitude is needed.
2. Focussing on what is caring, honourable, just, fair (not only on what is safe) can validate needs, and contribute to understanding/insight, recognition of basic needs, self-compassion, and (hope for) change in cognitions/emotions, self-commitment and commitment to treatment.
3. Acknowledging patients in their experiences can contribute to enriched communication on emotions/beliefs regarding nightmares.

5 | Conclusion

This study provides valuable contextualized insights and understanding of the phenomena that influence communication about nightmares within PTSD. Despite the detrimental effects of nightmares on daytime functioning and distress, the interviews revealed that the participants hardly ever spoke about their nightmares. This study's findings show that impaired trust, disloyalty and non-responsiveness to emotional needs can infringe integrity and identity, increase self-conscious negative emotions (shame, guilt, anger), and beliefs

(self-blame, inferiority, irrelevance, self-doubt). In turn, this impedes internal and external dialogue about nightmares and underlying traumas. Remaining silent about re-experiencing nightmares appears to contribute to maintaining the PTSD. Not communicating about nightmares/traumas, and the lack of receptivity or non-responsiveness in others prevent the individual from recovering. The first rehabilitation and recovery experiences are often gained within specialised therapy.

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Abstract
Introduction: Many people with PTSD are being visited by nightmares (50-70%). Nightmares have detrimental effects on daily functioning. No studies were available on how people with PTSD communicate about their nightmares.
Aim: This study investigates the lived experiences of people with PTSD regarding their communication about nightmares.
Method: Fourteen outpatients participated in a qualitative, phenomenological study. Data were collected through in-depth open interviews and analysed according to Colaizzi's method.
Results: Communication about nightmares was – as a result of traumatic experiences – strongly influenced by trust in others and in oneself. Non-responsive communication deepened distrust.
Initial experiences with responsive communication are usually gained in specialised therapy.
Although they may avoid communication, people with PTSD who experience longstanding, severe nightmares often think that nightmares are normal and that nothing can be done about it.
Discussion: Responsive and culture-sensitive communication regarding nightmares can contribute to a shift in underlying self-conscious, negative emotions/beliefs that obstruct nightmare communication.
Implications for Practice: Healthcare workers should actively ask about nightmares. Within an emotional-responsive and culture-sensitive communication approach, attention should be paid to negative emotions (guilt, shame, anger) and negative beliefs that contribute to low self-esteem, inferiority, loneliness, futility and obstruct communication.

Keywords: Communication, nightmares, PTSD, phenomenology.