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Rehearsal Relief of a Nightmare

By ISAAC MARKS

SUMMARY A recurrent nightmare of 14 years' duration rapidly disappeared after it was rehearsed repeatedly in treatment. The nightmare was independent of co-existing compulsive rituals and sexual problems, but was related to co-existing depression.

Case History

A woman aged 45 suffered from *depression* once or twice a year from 1964 onwards. For this she was admitted five times to psychiatric hospitals over the next three years, and had two courses of ECT which did not help her. In 1966 she had several fugues; her condition was diagnosed in a neurological unit as *temporal lobe epilepsy*, and she was kept on phenobarbitone, phenytoin and diazepam daily for several months. Thereafter no more fits occurred. In 1970 she had two further psychiatric admissions for 'confusion' and depression, and further depression was treated in 1973 by psychotherapy weekly for 9 months and in 1974–6 by group psychotherapy. Tricyclics improved her mood but not her rituals. In April 1976 at out-patients she described recurrent episodes, lasting a few hours, of overactivity, thinking ahead and feeling good for no reason; a sleep EEG was abnormal and suggested a chronic non-progressive organic disorder of the temporal lobes, particularly the right side. She then revealed her *compulsive rituals* for the first time.

For eight years she had carried out extensive checking of her possessions at home and at work, taking up to three hours a day. She thought her checks were silly and tried to stop them, but couldn't. They limited her social life and the evening studies she wished to pursue. There were no rituals concerning washing or dressing, nor ruminations. When away from her flat new rituals developed within a day or two. The rituals decreased during moderate depressive episodes and ceased when depression was severe.

Sexual maladjustment was another problem. The patient was ashamed of never having had coitus and feared she might be a lesbian, having had crushes as an adolescent, though no overt homosexual experiences. To avoid sexual advances she told her friends fantasies of invented lovers. She masturbated about three times weekly, to masochistic fantasies.

Family and background: The patient was an only child from a disturbed family. She had been very fond of her father, a dancer, who was an alcoholic and died in 1959, aged 55, of cirrhosis of the liver, after being for a year in a mental hospital with dementia. His wife, the patient's mother, after much quarrelling, had thrown him out of the house in 1953. She dominated the patient, was very possessive and never got on with her; she died in 1962, aged 60, of cervical cancer. Two maternal aunts and a maternal grandfather had depression; one of the aunts killed herself and the other attempted suicide.

The patient was born in Berlin. Her mother was German and single at the time, while her father was English. Her parents only married when she was 10. Her first two years were spent in a children's home in Germany; the mother then came from England to fetch her. The family wandered around Britain until the patient was 6. She only discovered her illegitimacy in 1962 after her mother's death, and was so upset that she tore up all the family photographs and threw away all her mother's possessions bar a book of poems. She felt guilty that she did not grieve for her mother, but was glad to be rid of one who had made her afraid, and who had been 'lovey-dovey one minute and looking daggers at me the next'.

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The patient sleepwalked in her room at age 6. At school from age 6 she did well academically and matriculated at 17. She had only one or two close friends, was not popular and did not go out much. Her work record was stable, her latest job, as a clerk, starting in 1974. She was a perfectionist woman, shy and quiet but forthright and stubborn, feeling a strong personality kept down by her mother. She lived alone in a flat since November 1975, and went to concerts with girl friends.

Treatment

In January 1977 the patient was admitted to hospital. She was moderately depressed with self-reproach about her virginity and her lies about a lover who did not exist, and felt worthless and that life was not worth living. Her compulsive rituals were treated for six weeks by 30 sessions of exposure *in vivo*, 10 of which were carried out in her home. On first hearing that the therapist (Dr G. Sartory) was German-speaking like her mother, the patient nearly refused treatment until she was reassured that Dr Sartory was Austrian and not German in origin. The rituals reduced rapidly with exposure treatment.

On February 23 the patient was seen at a ward round with a view to discharge the next day. The author had only seen her once before, in a similar round, for 15 minutes. The patient was unexpectedly tearful and tense, tearing tissue held in her hands to shreds. She explained that though her rituals had practically gone she had had a nightmare the previous night about her mother, and she revealed for the first time that these stereotyped nightmares had occurred every three months from 1963 onwards, starting a year after her mother's death. The nightmare would occur about 1 a.m., after which she would lie awake the rest of the night, remaining so upset the next morning that she would phone her workplace and not go in till the afternoon. She had never told the nightmare to anybody, not even in group psychotherapy, but it had never previously occurred on the night before she was due to see a therapist.

In front of the ten people at the ward round, the author encouraged the patient to relate her nightmare for the first time in detail; he placed his arm round her shoulder and asked her to close her eyes and to speak about it. Within a few seconds the content was disclosed with many tears and great tension, in a loud halting voice: 'My bloody mother, she degraded my father and me, but I'm determined to get well. In this nightmare she's standing on the roof and I come from behind and push her off. She falls to the bottom. I rush down the stairs and go outside to make absolutely sure she's dead. I find the head and body have separated, surrounded by pools of blood, which is a glorious sight. I'm still not sure that she's dead. Her penetrating eyes are looking at me. I put on long black shiny army boots and stamp on her head trying to crush it (I was always afraid of her, wouldn't say anything to her—only since she is dead have I tried to develop). Suddenly as I'm stamping on the head it starts lifting up, and protruding from each eye are spiky objects which come towards my eyes. It comes nearer and nearer and I try to back away but can't and am trapped, and finally these things sticking out of her eyes go into my eyes, and all goes jet black into total oblivion. This is terrifying and I wake up—*she bloody well wins doesn't she? My bloody mother*'.

The patient was then encouraged to relate the nightmare twice more, all three accounts together totalling no more than 20 minutes. Each time it evoked intense crying, ending with a shout of 'my bloody mother—she always wins'. Affect was less on the third occasion. She was encouraged to write a description of the nightmare and to try to rehearse triumphant endings. She was discharged the next day.

On March 2 she noted that she had been upset for 24 hours after she had relived her nightmare three times at the ward round. As requested, she had written down three dreams ending with triumph over her mother. As an example, one ended: 'I grab a well-sharpened knife and cut very, very deep into both her eyes. Blood and a yellowish substance shoots out straight into my face. I lick it with delight and begin to feel I'm winning. I throw the knife away and take both eyes out of their sockets with my bare hands. I crush the eyes tightly for several minutes watching with glee the blood

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ooze out from all directions. I continue until there are no solid pieces left, just puree in both hands. I take a towel and wipe my hands very thoroughly until there is no trace of my mother's eyes left. I throw the towel away and know I am the VICTOR'. She could not read out 'My bloody mother' which she had written. As an approximation to assertion against maternal authority, she was encouraged to say 'Bloody Dr Marks and Bloody Dr Sartory' several times. She did this first with great difficulty but it became easier with practice. She revealed that she had grieved for her father only 11 years after his death and had cried for two hours and thereafter could not talk about it.

By March 23 she had been back at work for a week and for the previous ten days had felt pleased to wake up and start the day, for the first time in 18 months. She felt more interested in things, rated her checking as 85 per cent better, and she was going out for dinner with women and couples. She still hated her mother more than she loved her.

Over the next year she was seen five times and each time said she was free of nightmares, never having been free of them for longer than three months in the 14 years up to February 1977. She continued to feel well apart from three spells of moderate depression each lasting a few days, during which she continued to work but cut down social activities. Checking was minimal. Independent ratings of her depression and obsessions, including a behavioural avoidance test, confirmed her improvement after one year. She had been promoted at work and was active socially and in sports, seeing friends of both sexes regularly, but as before avoiding intimacy or sexual relationships, which upset her. Masturbation continued to fantasies of being tortured. In August 1977 she revisited her childhood home, the roof of which featured in her nightmare, and felt sad briefly afterwards. She was able to swear easily at the author and at her mother. When last seen, at one year follow-up in February 1978, she felt confident that her nightmares would not return, as she could think of her parents without being upset—'I put them where they belong—on a shelf—not tucked away never to be seen'.

Discussion

The main point of this paper is that stereotyped nightmares of 14 years' duration disappeared after the patient relived them in detail three times and then wrote about them three more times giving the dream a triumphant ending. Total treatment time was three hours. The nightmare had not returned by 16 months follow-up.

Comparable cases in the literature are rare. The first was reported by Geer and Silverman (1967). They successfully desensitized a man of 22 who for 15 years had had a troublesome nightmare of being attacked, occurring 3 to 5 times weekly in stereotyped form, usually shortly after falling asleep. He was otherwise a stable well-functioning person. He was treated by 5 sessions of training in muscular relaxation followed by 7 sessions of rehearsing successive parts of the dream in temporal order. Each time the dream was imagined for a few seconds at a time. The frequency of nightmares diminished only after the third rehearsal session, when the patient was instructed to say when anxious 'It's just a dream' and then to continue the image. After the sixth rehearsal session several weeks later the dream did not recur. At six months follow-up the nightmare had disappeared completely, with no other change in function.

The same authors (Silverman and Geer, 1968) also desensitized a 19-year-old woman who had a recurrent twice-weekly nightmare of bridges and a chronic related phobia of bridges. Treatment imagery over seven sessions concerned real bridges rather than the nightmare proper. The nightmares were absent at six months follow-up. This reflects a common sign of improvement in phobic patients during exposure treatment, namely that phobia-related nightmares disappear as the phobia decreases.

Similar case reports of desensitization of nightmares and related fears were made by Shorkey and Himley (1974) and Cavior and Deutsch (1975), while Ross *et al* (1971) found that nightmares and associated head-banging decreased in frequency after desensitization. In the only controlled study so far, Cellucci and Lawrence (1978) noted in undergraduates that

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desensitization produced significantly more decrease in nightmare frequency and intensity than did discussion about the nightmares or the mere recording of nightmare frequency. Follow-up was incomplete.

Other methods have also worked. Implosion helped the nightmares of four women undergraduates (Haynes and Mooney, 1975). Examples of self-control of unpleasant dreams are described by Garfield (1976). A boy of 11 had had about twice a week over 18 months recurrent nightmares of being pursued by monsters (Handler, 1972). The therapist asked him to close his eyes and visualize the monster, and then together for 15 minutes they yelled among other things 'Get away and leave me alone'. The boy was asked to repeat this whenever the monster appeared, and did so on the one occasion he saw it in the next few days. The next week he had a few more minutes of 'monster-yelling' with his therapist, and over the ensuing six months had only two nightmares, neither about monsters.

Therapeutic components of rehearsal relief: There are at least three possible components. One is exposure, the deliberate reliving of the experience. This seems analogous to the reduction of phobias and compulsive rituals by exposure *in vivo*, in which the patient is brought into contact with the feared situation until anxiety dies down (Marks, 1978). Desensitization and implosion, which have also reportedly helped nightmares, are variants of exposure.

A related phenomenon is the improvement of some patients' prolonged grief reactions after forced mourning, during which they deliberately relive as many experiences as possible concerning the bereaved person (Ramsay, 1976; Gauthier and Marshall, 1977; Lieberman, 1978). The same applies to relief of war neuroses and of traumatic neuroses by the re-evocation of relevant experiences. In the present case dream imagery was facilitated simply by the therapist putting an arm round the patient's shoulder and asking her to close her eyes and to talk. Eye closure is a simple facilitator of imagery and is commonly used in desensitization and other imaginal techniques.

Was abreaction of the painful nightmare a therapeutic aspect of the exposure apart from the content itself? The experience of anxiety is not a necessary feature of implosive treatment of phobias but might be so for the relief of nightmares. In this patient much emotion was evinced during rehearsal of the dream, but its therapeutic role is unclear.

A third possible therapeutic component is that of mastery. The patient was asked to give her dream a triumphant ending, and she was encouraged to be able to swear at her dead mother. Geer and Silverman's patient only became able to continue the dream imagery in the face of anxiety by saying 'It's only a dream'. Similar mastery elements were present in the desensitization treatment of Cellucci and Lawrence (1978). Garfield (1976) cited evidence for the ability of people to learn to control their own dreams.

One is reminded of anecdotes about the coping style of dream interpretation of the Senoi, a tribe of jungle people living in mountains in Malaysia (Stewart, 1969). If a child related a falling nightmare, an adult would reply 'You must relax and enjoy yourself when you are falling. Falling is the quickest way to get in contact with the powers of the spirit world, the power is laid open to you through your dreams. Soon, when you have a falling dream, you will remember what I am saying. As you do, you will feel that you are travelling to the source of the power which has caused you to fall. The falling spirits love you. They are attracting you to their land, and you have but to relax and remain asleep in order to come to grips with them. When you meet them you may be frightened of their terrific power, but go on . . .'. Over a period of time, with this type of social interaction, praise or criticism, imperatives and advice, the dream that started out with fear of falling is said to have changed into the joy of flying.

Interrelationships of different problems: The content of this patient's nightmares obviously reflected her difficult relationship with her mother, who died a year before the nightmares and depression began over the same period. The nightmares only improved after their rehearsal, and improvement in the depression was enhanced after this. Onset and improvement thus occurred about the same time in the night-

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mares and the depression. Improvement in both was accompanied by a greater ease in thinking and talking about her parents. The patient's family history of depression probably contributed to her mood swings and depression, which was unreponsive to treatment by ECT.

The nightmares seemed independent of the compulsive rituals, which did not improve after four weeks of placebo treatment in out-patients, but reduced rapidly with subsequent exposure *in vivo* as an in-patient. Was the guilt about her mother related to the rituals? This seems unlikely, as the rituals only began seven years after the mother's death, and the guilt remained after remission of the rituals. Guilt only decreased after rehearsal treatment of the nightmare. The patient's problems with sexuality and with intimacy followed a course independent of her other difficulties and did not change over the entire period she was seen.

It is not clear when this patient's mainly right-sided temporal lobe pathology began, or whether it facilitated development of her nightmares, depression and childhood sleepwalking. While night terrors can accompany epileptic activity, this patient had had no other clinical features of temporal lobe epilepsy for seven years. Irritability and aggression during her admissions from 1964 to 1970 might have reflected epileptic activity. Right temporal foci have been associated with manic-depressive psychosis (Flor-Henry, 1969) and with sadness (including depression), obsessive orderliness and inhibition of expressed anger (Bear and Fedio, 1977), all of which features were present in this patient. In Bear and Fedio's series, open expression of anger was more a feature of left-sided epilepsy.

In brief, this case and a few others in the literature suggest that rehearsal relief is worth trying as a treatment for recurrent nightmares. The approach seems related to that of exposure and of forced mourning.

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