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Brief Clinical Reports

''NOW I LAY ME DOWN TO SLEEP'': COGNITIVE-BEHAVIOURAL TREATMENT OF AN UNUSUAL OBSESSIONAL RITUAL

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Abstract. The assessment and treatment of an unsuaul pre-sleep ritual are described. The patient had unusual ideas about the probability and consequences of self-harming behaviour in sleep, and averted such behaviour through a ritual with possibly dangerous consequences. The origin and maintaining factors of the ritual are described; a cognitive-behavioural approach was used to treat the ritual, with successful results.

Keywords: OCD, rituals, phobia and exposure treatment.

Introduction

The fear of causing or failing to avert harm to self or others has been described as one of the defining characteristics of obsessional thoughts and compulsive rituals (Salkovskis et al., 2000). In particular, Salkovskis and colleagues have demonstrated that those who suffer from obsessive-compulsive disorder have an inflated notion of their responsibility for averting possible harm (Wroe, Salkovskis, & Richards, 2000). Typically, the sufferer has an exaggerated notion of the likelihood of some particular bad outcome, combined with the thought that if this should happen, it would be awful, and the idea that one who does not do enough to prevent it is blameworthy. For example, imagine a mother who fears that her baby may become ill and die through contact with germs on her hands; she is likely to overestimate the level of danger caused by unwashed hands, and also blame herself for any failure to wash ''adequately''. Behavioural treatment of obsessive-compulsive disorder can

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be conceptualized as a way to make sufferers re-evaluate their inflated notions of danger and responsibility.

We here present a case of an unusual obsession that was treated through an exposure hierarchy. The patient had a highly inflated idea of the risks posed by a normal everyday action, namely, going to sleep, and had developed a maladaptive coping strategy that fortunately she was helped to give up.

The case

Jane (not her real name) was a civil servant in her thirties, with a long history of a particular compulsive behaviour: on most nights she would lock herself in her bedroom and then lock the bedroom key in a toolbox. This behaviour had become increasingly elaborate over the years; she had begun locking herself in as a teenager, after her older sister had told her the story of a boy who had ''jumped out his window while asleep''. Jane interpreted this as an act of suicide while asleep, rather than as, for example, an accident that occurred while sleepwalking. She found this idea very frightening and seemed to find the idea that one could commit suicide while asleep, even if one is not suicidal in waking life, intrinsically believable. Her willingness to believe this rather odd idea seems to have grown out of her mother's peculiar psychological state, in that her mother seemed to have a number of paranoid beliefs, believing that Jane was weak and might be led astray by other people. For example, she once accused some of Jane's friends of putting drugs on Jane's coat in an effort to drug her and possibly force her into prostitution. Jane found her mother very difficult throughout her childhood, but she does seem to have accepted this idea of herself as a vulnerable person liable to be ''led astray''. Following the discussion with her sister, she began to take precautions against the possibility that she might harm herself while asleep, initially locking herself in her room at night.

Over the years between the beginning of this fear and her referral to our service, Jane had developed a very elaborate set of rituals. Her fear was that she might, while sleepwalking, obtain a large, sharp knife and stab herself to death. Every night she would lock herself in her bedroom and then lock the bedroom key, along with dangerous objects like razors, scissors and medicines, in a toolbox, which she would then fasten with four combination locks. She followed a set procedure, which included locking each lock, twirling the dial for about two minutes and pulling each lock 15 times, as well as various kinds of ''checking'' involving visual inspection and tapping of the box. She also put on a cross and chain for ''protection'' and checked that the digits on the alarm time did not add up to an ''unlucky'' number. We were able to establish that the complete ritual involved 36 separate steps. This ritual was quite time-consuming, and carrying it out prevented her from travelling abroad and made her very reluctant to enter into a relationship.

Interestingly, Jane's ideas about the reality of the risk of self-harm during sleep seemed somewhat distorted. Since she kept no large knives in her home, she would have had to obtain a knife while sleepwalking before actually being able to stab herself, yet she still felt that this represented a real danger. During the first assessment session we asked if she worried about the danger of being locked in her bedroom might make her vulnerable if her house were to catch fire. She stated that this did not worry her at all. She also stated that being stabbed to death seemed to her a much worse fate than being burned to death, a reaction that we believe to be quite unusual, since most people seem to regard death by fire

as one of the most unpleasant. In spite of her fears, Jane did state that she had occasionally been able to omit her ritual if she were staying away from home. She had also been able to enter into a relationship, and she was able to omit the ritual when her boyfriend slept with her. However, she was very worried about giving up the ritual, both because of her fear of self-harm and because she believed that, should she omit her ritual, her sleep would be very disturbed. She was concerned that if this happened she might be unable to do her job, leading perhaps to her being disciplined or even fired.

Treatment

Jane initially seemed ambivalent about treatment. On the one hand, her ritual did not impinge to a great deal on her day-to-day functioning. However, she felt that it made her ''abnormal'' and she felt ashamed of it; also, it seemed likely to interfere with an important long-term goal, to marry and have a family. We discussed possible treatment with her and suggested that she should think her options over and contact us if she wanted to be treated. This was intended to give her a greater sense of commitment to the treatment, and in fact she did contact us. Four assessment sessions were needed before we could completely detail all the steps of her ritual, since she found talking about them difficult and shaming.

Once a complete list of Jane's rituals had been made, the main element of her treatment was the elimination of a set number of rituals between weekly treatment sessions. This approach was collaboratively devised between Jane and her therapist (KK); during each session, they would discuss which steps she wished to eliminate. Jane followed this plan meticulously, keeping a weekly record of the number of rituals she performed each night, and by session 12 she was ritual free (see Figure 1; note that some of the sessions were spaced out and that Jane collected data on the weeks between sessions). During this period Jane experienced a rise in anxiety, and she was taught relaxation exercises to help with this; she described herself as, in general, someone who found it hard to relax and felt the need to be busy and productive, and the exercises helped her with this problem. Two sessions were devoted to a discussion of relapse prevention, and specifically to what to do if Jane was tempted to resume her rituals. At two follow-up sessions Jane continued ritual free, although she did have some residual symptoms such as fear of large knives. She also reported that she had been able to take a two-week holiday for the first time in her life. In general, Jane described herself as very satisfied with the treatment.

Discussion

This case illustrates the role of early experiences and beliefs in the formation and maintenance of obsessional behaviour. Her mother's rather paranoid worries combined with her sister's story to create what might seem to an outsider to be a very bizarre fear. Once established, the obsessional behaviour was maintained by an idiosyncratic view of both the probability and aversiveness of the feared consequence. Thus, Jane discounted a seemingly much more likely event, a house fire, in which a locked bedroom door could have fatal consequences, seeing it as both less likely and less frightening than self-harm during sleep. In spite of this, her desire for a normal life, including relationships, children and travel, and her sense of shame at what others would see as bizarre behaviour, motivated her to accept and take advantage of treatment. Treatment was almost entirely behavioural but, as far as

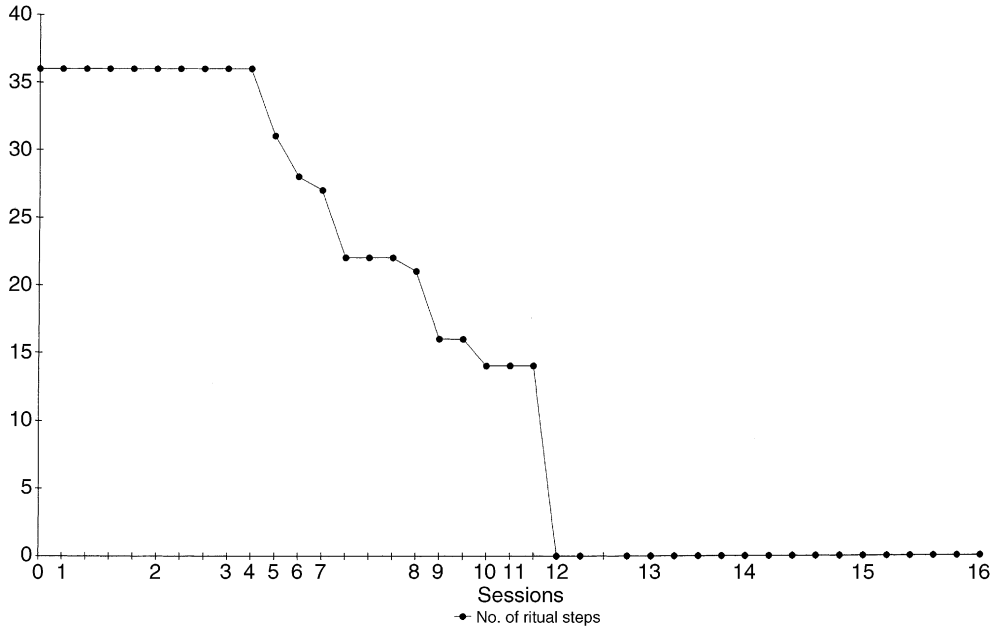

Figure 1. Reduction of rituals over time

we could tell, it also changed her perceptions of the risks of possible sleepwalking and of her responsibility for averting them, although we did not actually measure these cognitions directly. Her residual fears suggest that she had a continued fear of involuntary self-harm, but her continuing to be ritual free and follow-up and her enjoyment of a foreign holiday suggest that her gains should continue to be maintained.

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