American Journal of Clinical Hypnosis
49:2, October 2006

Hypnotic imagery rehearsal in the treatment of nightmares: A case report

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Abstract

This case report discusses a patient who experienced frequent nightmares and chronic low-level anxiety during his 3½ year imprisonment. He developed post traumatic stress disorder (PTSD), in part because he adamantly insisted that he had been wrongfully incarcerated. The literature supports the use of hypnotic imagery rehearsal for treating nightmares that stem from PTSD. Due to the patient's distrust of others and trauma history, it was uncertain whether hypnotic intervention would be effective. It is of note, there is no indication in the literature that hypnosis has been used with people on parole, let alone individuals who believe they were wrongly accused of committing a crime.

Keywords: Nightmares, hypnotic imagery rehearsal, wrongful incarceration, post traumatic stress disorder

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Trauma symptoms impact individuals in a variety of ways, often manifesting as nightmares. There is growing evidence to support the use of imagery rehearsal therapy as one of the most effective treatments for nightmares. (Germain, Krakow, Faucher, Zadra, Nielsen, Hollifield, et al., 2004; Krakow, Sandoval, Schrader, Keuhne, McBride, Yau, et al., 2001; Krakow, 2006).

Incarceration is an example of a traumatic event that often has a profound effect on prisoners. Case studies have documented nightmares in incarcerated adults and juveniles who committed crimes, but no research has documented wrongly accused adults and their related nightmares (Halliday, 2004). This paper explores the use of hypnotic imagery rehearsal while the patient experienced nightmares both during incarceration and when he was on parole. It is important to consider treatment with this population since 6.9 million Americans were reported to be incarcerated, on probation or parole, a 275% increase since 1980 (Bureau of Justice Statistics, 2005).

A traumatic event is not restricted to a person's past in the same way that other life events may be cataloged and filed in the brain. Instead, they intrude upon visual, auditory, and/or other somatic realities (Rothschild, 2000). Traumatized people frequently lose signal anxiety, thus are unable to modulate their level of arousal. Reactions to benign stimuli are similar to reactions to threatening stimuli, and the person becomes frozen in a hyperaroused state (Bloom, 1997). Lacking a verbal narrative these traumatic sensations and images become encoded and released as flashbacks and nightmares (Herman, 1992). Interventions such as hypnotic imagery rehearsal may be useful to change these images into something safer and less intrusive. Hypnosis research and practice supports the use of a wide range of clinical applications. Yet there has been limited investigation into its application for diverse populations.

Case History

"Max" is a 23-year-old Caucasian male. He was referred to me by his "wife's therapist," – his wife suggested that he try hypnosis to manage his chronic anxiety. Max worked in the construction industry and had limited employment opportunities as a result of his felony charge and conviction.

This is a brief summary of his life history: At age 12 his parents divorced and he was left with his alcoholic mother, who was frequently passed out, or screaming, or neglectful. As a result, outside the home, he was often left alone on the streets of his unsafe neighborhood. Max's life became one of survival and instinct instead of reason and insight. His temper led him to many physical fights, which became his primary mode of communication and expression. He was an imposing figure at a tattooed, muscular 6'3" build.

Max was imprisoned for 3½ years for the armed robbery of a gas station, but insisted upon his innocence. Max's version of the incidents preceding his arrest was that the police had shown him surveillance camera footage of a man robbing the store who did not resemble him; that after his arrest the police severely assaulted him and knocked out several of his front teeth; and that a confession was coerced out of him after he was physically assaulted and forced to stand handcuffed for over 8 hours without food, water, or a bathroom break.

Since his release one year before, he had nightmares about being chased by police or returning to jail at least once a week. Additionally, his wife would awaken him during the night because he would moan or thrash in his sleep, though he did not remember these

nightmares. He had tremendous difficulty being alone, at which time he experienced high levels of anxiety. At all other times, he experienced a persistent low-level anxiety, which he denied having prior to imprisonment. He frequently obsessed about minor stressors including his job, finances, and his marriage. Additionally, he reported a chronic depressed or apathetic mood and little excited him. These symptoms appeared to have been present prior to incarceration.

The patient denied any use of recreational drugs or alcohol, according to the rules of his parole. He had no prior treatment. According to the DSM-IV, Max met the criteria for post traumatic stress disorder with comorbidity of dysthymia and generalized anxiety disorder (American Psychiatric Association). Max agreed to come for weekly sessions until the symptoms abated.

Description of Treatment

First session

Max was taught self-hypnosis for general anxiety management using progressive muscle relaxation or concentrating on an external focal point. I also helped to guide him to establish an imagined safe place to return to in any subsequent hypnosis sessions and self-hypnosis. He was not asked to reveal his safe place. In prison, inmates have no privacy and every available decision is taken from them. By encouraging Max to keep his safe place secret, I hoped to help him to feel a sense of individual control during this initial session.

After self-hypnosis was taught, formal induction with eye-fixation was employed using both direct and indirect suggestions for comfort, relaxation, and safety. The patient was encouraged to increase his sense of comfort using therapeutic metaphors. Post-hypnotic suggestions were used to assist in helping the patient to remember to practice self-hypnosis.

Second session

After the patient was given general instructions for relaxation, I suggested that Max attempt to remember incidents from 2 years before when he was imprisoned. Ideomotor signaling was used to assess his anxiety level throughout the session. Max's right and left index fingers indicated "yes" and "no" respectively. When asked if he experienced anxiety when imagining prison, his right index finger (yes) raised with an extreme tremor. He experienced tremendous anxiety immediately when he was regressed to the traumatic scene and he was reoriented to the present and returned to an imagined safe place.

Bringing the patient back to the trauma caused him undue distress. It seemed more practical to continue to help the patient establish a sense of safety and comfort instead of attempting to change feelings associated with the memory of the anxiety-producing scenario. Therefore, I encouraged the patient to visualize images that evoked comfort.

Third session

The patient reported that his chronic low-level anxiety seemed lower. He had fewer intrusive fears about potentially being arrested and felt less muscle tension. He also practiced self-hypnosis which he reported physically relaxed him.

Max was asked to focus on an object until his body felt relaxed. After he indicated his relaxation, I used therapeutic metaphors to suggest changing nightmares or unpleasant memories into pleasurable experiences. I told a story about Hypnos, the God of Sleep and his son Morpheus, the God of Dreams to assist him in reframing anxiety dreams into more pleasant

scenarios. I also encouraged Max to review any further spontaneous traumatic images as if they were being viewed from a great distance. I suggested it would be like watching these scenes in a movie and associating relaxed and comfortable feelings with these images.

Results and follow-up

Max decided to continue psychodynamic treatment to address his traumatic childhood and anger management issues. Prior to treatment he had at least one nightmare per week and experienced chronic low-level anxiety. Six weeks subsequent to hypnotic intervention, Max denied having any nightmares. He still experienced high anxiety when alone but the persistent low-level anxiety had vanished. One year later, he reported two nightmares during that year subsequent to the initial hypnosis session; one nightmare on his birthday and one nightmare on the anniversary of his arrest date. He did not report any additional nightmares.

Discussion

People who are imprisoned often experience nightmares or flashbacks of traumatic events and become easily startled (Gibson, et al., 1999). PTSD is common among the prison population. Inmates who have met a 6 month criteria for PTSD were more likely to meet diagnostic criteria for major depressive disorder, obsessive-compulsive disorder, and generalized anxiety disorder than inmates without a current diagnosis of PTSD. (Gibson, Holt, Fondacaro, Tang, Powell, & Turbitt, 1999).

The patient's subsequent hypervigilance after incarceration was necessary to preserve his sense of self. His sense of safety and autonomy was disrupted and unable to be wholly repaired after his arrest, assault, and imprisonment for a crime he said he did not commit. In addition, he experienced a loss of control by having to adhere to a curfew, be subjected to random searches, and the possibility of being arrested again for any minor parole violation.

Initially, I was uncertain if hypnotic intervention would be successful and provide rapid relief. Max spent his life being hyperaware of his surroundings, and continued to feel anxious because of parole restrictions. He had very few people in his life that he trusted and his ability to relax completely upon a first visit with a stranger (the therapist) was unexpected. However, Max had exhausted his personal resources in attempts to decrease his anxiety and nightmares and had failed to improve. Hypnotic intervention seems to have worked well for this patient, in part, because of his high motivation to relieve his symptoms.

There are obvious limitations with a single case example, since the results are not generalizable to the larger population. This case report demonstrates the need for more intervention work with this population. Hypnotic imagery rehearsal may have larger implications in terms of addressing hyperarousal states and potentially reframing traumatic memories or flashbacks from posttraumatic stress disorder.

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