



Effectiveness of a manualized imagery rehearsal therapy for patients suffering from nightmare disorders with and without a comorbidity of depression or PTSD

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ARTICLE INFO

Article history:

Received 25 October 2011

Received in revised form

8 May 2012

Accepted 16 May 2012

Keywords:

Nightmare disorder

Nightmare

Imagery rehearsal therapy

Depression

PTSD

ABSTRACT

Nightmares are a common and serious problem in psychotherapeutic practice, although they are seldom considered as independent mental disorders. There are some promising approaches to the treatment of nightmares, notably *Imagery Rehearsal Therapy*, a cognitive-restructuring treatment. The core of this approach is the modification of the nightmare script and repeated imagination of the new script. However, most evaluation surveys have been conducted only with trauma patients, and thus far there is no standardized manual in the German language. 69 participants were examined using self-rating questionnaires. Participants belonged to three groups: 22 primarily nightmare sufferers, 21 patients with major depression and nightmares, 26 with PTSD and nightmares. 12 of the PTSD patients were randomly assigned to a control condition. Primary outcome measures were nightmare frequency and anxiety during nightmares. Overall, nightmare frequency and the anxiety they caused decreased following the treatment. Nightmare frequency and anxiety during the nightmares were highest in the PTSD group initially. Nightmare frequency decreased in all groups. Anxiety scores decreased least in PTSD patients, in depressive patients and primarily nightmare sufferers anxiety scores decreased during intervention. In primarily nightmare sufferers anxiety remained low up to the catamnesis period as well. Thus, those who suffered primarily from nightmares showed the strongest benefit from the nightmare treatment.

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Introduction

Nightmares are a common psychological experience. They are typically defined as repeated awakening from sleep while recalling intensely disturbing dreams, usually involving fear or anxiety, but also other negative emotions such as anger or disgust (Schredl, 2009a). Awakening typically occurs in the second half of the sleep period during Rapid Eye Movement (REM) sleep. The person awakens and is quickly alert and oriented (DSM-IV-TR, American Psychiatric Association, 2000; ICSD-2, American Academy of Sleep Medicine, 2005; ICD-10, WHO, 2005). The criterion of awakening has been disputed. Nightmares that lead to awakening are assumed to be more intense than those that do not lead to awakening, but there is a large overlap (usually referred to as “bad dreams”; Schredl, 2009a; Spoomaker, 2008; Zadra & Donderi, 2000). Nightmares can occur either on their own or with a concurrent psychological disorder, such as depression, anxiety, schizophrenia, borderline

personality disorder and, in particular, post-traumatic stress disorder (PTSD; Hartmann, 1984; WHO, 2005).

Ten percent of adults report nightmares at least once a month (Belicki & Belicki, 1986; Levin, 1994). Prevalence rates of people who suffer from their nightmares are about 3–5% (Schredl, 2010; Spoomaker, Schredl, & van den Bout, 2006). Methodological aspects differed between the various epidemiological studies, and there is no consistent criterion for frequency or duration, but the aspect of suffering was relevant in most studies. Women report nightmares more frequently than men (Levin & Nielsen, 2007; Schredl & Reinhard, 2011), an effect not found in children, thus gender effects occur up from adolescence and narrows with increasing age (Schredl & Reinhard, 2011). Younger people have more nightmares than older people with the highest prevalence rates found between the age of five and ten (Schredl, 2009b).

Hitherto, nightmares have not been a major focus of treatment in behavior therapy. For the most part, they have been regarded as symptoms of an underlying disorder, believed to vanish once this disorder has been treated. Nonetheless, there are several reports of successful treatment of nightmares (overview: Spoomaker, 2008), for instance with various cognitive-behavioral techniques such as exposure (Burgess, Gill, & Marks, 1998; Grandi, Fabbri, Panattoni,

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Gonnella, & Marks, 2006), systematic desensitization (Cellucci & Lawrence, 1978; Miller & DiPilato, 1983), or imagery rehearsal therapy (Krakow, Kellner, Pathak, & Lambert, 1995; Krakow & Zadra, 2006), as well as hypnosis (Kennedy, 2002; Seif, 1985).

Imagery rehearsal therapy (IRT) is based on earlier approaches which used the rehearsal of the nightmare with a modified ending (Bishay, 1985) and is comparable to the transformation technique in hypnotherapy (Kennedy, 2002). IRT consists in the rehearsal of the modified dream using imagination techniques instructing patients to create a new dream script. Several studies have found a positive effect of IRT on nightmare frequency and nightmare distress (Forbes et al., 2001, 2003; Krakow, Hollifield, et al., 2001; Krakow, Johnston, et al., 2001; Krakow, Kellner, Neidhardt, Pathak, & Lambert, 1993; Krakow et al., 1995; Lu, Wagner, Van Male, Whitehead, & Boehnlein, 2009). However, studies describing a successful application of IRT in nightmare sufferers were mainly undertaken in a group-therapy setting. In earlier studies, participants received information on how to imagine a new dream script and practiced the imagination technique in only one session. Subsequently, the participants were instructed to practice the technique at home on their own (Krakow et al., 1993, 1995). Most of the more recent studies examined the nightmare treatment of PTSD patients (Forbes et al., 2003; Krakow, Hollifield, et al., 2001; Krakow, Johnston, et al., 2001).

Our goal was to adapt this approach for an individual therapy setting and patients suffering from nightmares only, as well as patients suffering from other mental disorders such as depression and PTSD as well as nightmares. As there was no standardized therapy for nightmares in German, we developed a nightmare treatment for an individual therapy setting and standardized the instructions and exercises according to a manualized therapy based on IRT (Thünker & Pietrowsky, 2011). Moreover, we added specific adaptations for traumatized patients, namely an additional imagery exercise (“the safe place”) and a technique designed to minimize the nightmare – and therefore trauma – confrontation during nightmare reconstruction.

The present study was designed to test the effectiveness of this standardized nightmare therapy (Thünker & Pietrowsky, 2011) in patients suffering from nightmares only (“primarily nightmare sufferers”), as well as patients suffering from nightmares associated with major depression and PTSD. We expected all patient groups to benefit from the standardized nightmare therapy with a reduced nightmare frequency and lower nightmare intensity (i.e. less anxiety during the nightmare). We also expected a reduction of the number of awakenings due to the nightmares and a lower level of daytime distress on the day after the nightmare. Since the number of nightmares and the distress on the day after a nightmare are only moderately intercorrelated, daytime distress following a nightmare is more likely to be associated with personality variables like psychopathology or personality traits (Blagrove, Farmer, & Williams, 2004; Levin & Fireman, 2002; Schredl, Landgraf, & Zeiler, 2003). Thus, daytime distress following a nightmare was assessed as an important dependent variable within the context of nightmare treatment. Therapy effects were expected to last up to the follow-up measurement ten weeks after the end of treatment. To control for unspecific treatment effects, effects in PTSD patients were compared with a randomized control group receiving treatment as usual which was expected to have inferior effects on the examined outcome measures.

Method

Participants

Patients primarily suffering from nightmares, patients with major depression and nightmares and patients with PTSD and nightmares, older than 18 years, were included in the study.

Patients with acute substance abuse or psychosis were excluded. The primary inclusion criterion was that the patients suffered from their nightmares, while duration of nightmares as well as awakening were no criterions. Patients who had less than one nightmare per month on average were not included. A total of 72 participants were recruited from psychotherapeutic and psychiatric outpatient departments, a hospital for traumatized patients, general medical practices, daily press and adverts at the university. After being given a description of the study, participants provided written informed consent. A structured diagnostic interview for ICD-10 was conducted (Mini-DIPS; Margraf, 1994) and 69 of the recruited patients could be assigned to one of the three groups (22 primarily nightmare sufferers, 21 patients with major depression and 26 patients suffering from PTSD and nightmares; Fig. 1), the remaining 3 patients either did not fulfill the inclusion criteria or rescinded their assent to participate to the study. In the PTSD group, patients were randomly assigned to an intervention and a waitlist control condition who got a trauma-specific psychotherapy but no nightmare treatment (treatment as usual). The nightmare intervention was offered to all patients from the waitlist after completion of the study. 8 patients of the depression group were already in ambulant cognitive-behavioral psychotherapy at the beginning of the intervention period, that was reasoned by convergent expectancies (patient preferred dream interpretation rather than nightmare reduction), loss of interest, the beginning of inpatient treatment, problems reaching therapy without a car, and one patient could not be contacted at all. Additional 3 patients of the control group dropped out during the waiting time (one not contactable anymore, one with no interest, one feeling too unstable; for an overview see Fig. 1). Most of the patients were concurrently receiving psychotherapy and/or antidepressive medication. For further descriptive data of the samples (sex, age, psychotherapy and medication) see Table 1.

Design

The study comprises a pre–post comparison with three patient groups, as well as a randomized waitlist comparison in the PTSD group (compare Fig. 1). In the pre–post comparison, nightmare frequency and anxiety during the nightmares were assessed prior to therapy (pre-measurement), immediately after the therapy (post-measurement), and after a follow-up period of ten weeks (follow-up measurement) in the three groups of patients (primarily nightmare sufferers, depression, PTSD). In the control group, the same data were collected at the beginning of a ten-week waiting period and after the ten weeks. These data were compared to the data of the PTSD intervention group. Since these patients were offered nightmare therapy after the second measurement, no follow-up measurement was possible in this case.

Nightmare therapy

The standardized nightmare therapy (Thünker & Pietrowsky, 2011) consisted of 8 therapy sessions of 50 min each. Therapy lasted ten weeks, with sessions 1 to 7 held on a weekly basis, the eighth after a delay of 3 weeks. Between therapy sessions, patients were instructed to practice the techniques learned. Worksheets, handouts and an audio CD were handed out to support the patients.

In the first session, patients received information on the therapy and the rationale underlying the imagery rehearsal technique. Information about dreams and nightmares in general (epidemiology, etiology) and healthy sleep behavior was provided. Patients were instructed to keep a record of their nightmares during the intervention period. In the second session, a relaxation technique

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