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The Screening Function of Post-Traumatic Nightmares

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I

Nightmares, especially post-traumatic nightmares, have posed major problems for the theory of dreams. If it is presumed that the manifest dream is virtually unmodified representation of the traumatic event - something like a vivid, affect-laden night-time memory - then it would seem that the manifest and latent 'content' of the dream are identical, and there is neither dream work nor the representation of unconscious wishes as fulfilled, nor the need for distortion and disguise that accompanies the expression of unconscious wishes. Furthermore, since nightmares are anxiety dreams which wake the sleeper, the function of dreams as guardians of sleep is not in evidence. Affects in dreams are presumably dampened but certainly not amplified (Freud **1900**, p. **467**). Accordingly, the enormity of affect - which has made the word 'nightmare' paradigmatic for overwhelmingly frightful experience in the face of which one is helpless - seems to belie the stimulus modulating function of dreams.

Perhaps the most perplexing feature of the nightmare revolves around the issue of wish fulfilment. If a dream is the disguised expression of an unconscious wish represented as fulfilled, how is one to account for the generation in dream life of an unmodified replay of an experience of sudden and overwhelming trauma? The dream, in recreating the terrifying experience, seems to act in ways utterly different from that in which stimuli or wishes are represented as fulfilled by the consummatory act of hallucination that we call dreaming.

These issues, of course, have a prominent place in the history of psychoanalysis. Writing of anxiety dreams, Freud **(1900)** was careful to demonstrate that such dreams were only apparent contradictions of the theory of wish fulfilment. The anxiety, he took great pains to point out, belonged not to the manifest dream scene which appeared to generate them, but rather to the latent dream's thoughts (p. **580**), and were reflective of the conflict (either libidinal stasis, or later a signal of danger) between the unconscious wish and the forces of censorship.

But the problem of post-traumatic dreams does not seem explicable in these terms. If the manifest dream is presumed to be an exact replay of the traumatic situation, then there is no evidence of the existence of latent content, unconscious wish, or anxiety stemming from an intrapsychic conflict. The very notion that dreams have the function of keeping the sleeping psyche from being disequilibrated by sleep-threatening stimuli seems not to apply to the case of post-traumatic nightmares.

Freud did pay considerable attention to these phenomena. In the wake of World War I experiences with combat nightmares, and with the evolving of psychoanalytic theory and clinical experience, he postulated in 1920 the compulsion to repeat. This

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compulsion to repeat can be seen as a wish *from the ego*, originally overwhelmed, but preparing itself in both dreams and repetitive acts to replay and eventually to master overwhelming traumatic experience. Post-traumatic dreams then were 'beyond the pleasure principle', that is, attempts of the once overwhelmed ego at mastery. In these anxiety-laden repetitions, the psyche amplified rather than diminished threats to its equilibrium. In later works Freud remained sceptical that traumatic dreams really go beyond the pleasure principle **(Freud 1933)**. The subsequent history of psychoanalysis has seen a movement toward considering nightmares through frames of reference that are not exclusively psychoanalytic nor even clinical. The tendency even among psychoanalytic investigators has been to consider nightmares in the light of recent laboratory findings from sleep and dream research (**Fisher *et al* 1970**, **Hartmann 1984**).

This communication concerns *chronic* post-traumatic nightmares 'n an inpatient psychiatric population'. The sample, therefore, is limited to patients sufficiently impaired to require at least one, and usually more, psychiatric hospitalisations. The investigation was phenomenologically based, clinically rich, psychoanalytically informed and psychodynamic, but it does not derive from the psychoanalytic nor even from the psychotherapeutic situation itself. The study of chronic post-traumatic nightmares is part of an effort to study all nightmare experiences of that inpatient psychiatric population over a period of time. The overall project included nightmares that were non-traumatic and those that were acute. In the overall study from which the current communication was derived, most post-traumatic nightmares were chronic, having occurred for the most part more than a decade later than the trauma represented in the nightmare scenario. Thus I cannot assume that the sample of nightmares, the chronic ones in particular, are the same phenomena as the type of nightmare that follows shortly after a traumatic event and in persons otherwise free of psychiatric disorder. The fact that the entire study was drawn from an inpatient psychiatric population provides a stern cautionary against generalisation of these findings to nightmare sufferers outside of the specific type of population and type of nightmare represented in this study.

Post-traumatic nightmares are usually described in the literature, even psychoanalytic literature, as though they were unmodified reproductions of the traumatic scene replayed in exact or almost exact detail. That is also the way the dreamer experiences them. Such dreams appear to have a somewhat different biological substrate from that of nightmares of lifelong nightmare sufferers **(Hartmann 1984)**.

Traumatic nightmares usually occur in NREM sleep, in the middle of the night. Those of lifelong nightmare sufferers occur in REM sleep, and more towards morning. Much of the recent literature on nightmares tends to view these dreams as markers of stress response, not as products of the imagination, deriving from an excess of stimulation and functioning to keep the psyche in more modulated equilibrium; not as freshly woven ideational product revealing details of the patient's history and psychic disequilibrium and woven from the pattern of personal experience making use of recent and indifferent materials for the dream collage. That is to say, nightmares tend to be overlooked as true dreams in the psychodynamic sense, having *meaning* not just in relation to trauma but also to the dreamer's entire psychic continuity, and having the *function* of modulating excessive disrupting stimuli by representing them in a less disturbing way, as fulfilled wishes.

Most patients in our sample were interviewed one or more decades after the trauma occurred. Accordingly, the study throws rather limited light (two patients in a sample

of 40 nightmare sufferers, 15 of whom had post-traumatic nightmares) on acute post-traumatic nightmares. Such nightmares often, but not always, seem to the dreamer to be simple replays of the traumatic event. Most patients in this sample suffered traumata one to four or more decades before the most recent nightmare about which they were questioned. It has been observed **(Hartmann 1984)** that within a few weeks or months post-traumatic nightmares begin to blend with other dream elements and eventually to disappear. One would expect that acute post-traumatic nightmares as stress-response imagery would have a relatively short natural history. Nonetheless, clinical experience, as well as experience in the literature, point to the chronicity of nightmares. Although there is mention in the literature **(Van der Kolk 1984)** of chronic nightmares, I could find nothing in the literature attempting to explain the chronicity of these nightmares nor what factors would tend to support the continuation of repetitive nightmares occurring over a period of years to many decades. Why do some blend with other dream elements after a few weeks to months and cease to be nightmares, while others persist for years or even decades? I attempt to illustrate with clinical material factors which bear on the chronicity of post-traumatic nightmares.

II

The investigation took place in a 20-bed inpatient unit at the Brentwood Division, West Los Angeles VA Medical Center. The ward, a centre for psychiatric residency training, has both a psychodynamic approach to the patient and a commitment to an exploration of, and involvement with, that patient's family system present and past.

The interest in nightmares was given impetus by psychotherapeutic contact with combat veterans and with patients who had suffered physical or sexual abuse as children. Both of these groups of traumatised patients tended to have a high prevalence of chronic nightmares. The ward did not select its admissions based on an interest in such patients.

On admission every patient was asked if he or she had nightmares (Lansky & Karger, unpublished). There were no pre-established criteria for what was and what was not a nightmare. The patients were later asked why they had called the dream experience a ‘nightmare’, and there was enough uniformity in the answers to give a reasonable working model. All had awakened from sleep out of fear, most felt helpless, some even tried to escape the dream scene. The method of study was to combine clinical knowledge of the patient with an open-ended written questionnaire. That questionnaire was filled out prior to an interview of 30 to 60 minutes which covered and amplified what was written by the patient. The interview was tape recorded.

It is noteworthy that all 40 patients who acknowledged having nightmares consented to fill out the questionnaire and to participate in the taped interview. There were follow-up interviews with some patients. Most were eager to pursue the topic once it was open and wanted to talk more.

The questionnaire was deliberately open ended and left room for a detailed account of the patient's most recent nightmare, details of events and emotional states surrounding the nightmare experience, and the psychic and bodily feelings experienced after awakening. The patients were asked about their first and other nightmares. Patients were asked for their views about the relationship of any of these to the experiences of trauma, to childhood experiences, to the current family situation and to the treatment setting. The last section of the questionnaire covered details of the current family situation and the family of origin. These data are certainly not

equivalent to an associative anamnesis, particularly one that takes place in the context of an ongoing treatment relationship. Nevertheless, an astonishingly reflective mode of self-inquiry was established rapidly with most patients, even those whose treatment alliance and observing ego had seemed minimal or even absent prior to the investigation. This heightened reflectiveness made possible a limited but significant use of the associative method, and even brief forays into interpretive synthesis that was useful to the treatment enterprise. The purely investigative data co-mingled with the knowledge of the patient's current situation, based on 24-hour ward observation and data from supervision of meetings with patient and family.

This blend of investigative data, clinical material and results of intensive family study gave a uniquely rich perspective on infantile (familial) trauma, on current familial dysfunction, and on specific current difficulties viewed in the treatment setting and the patient's current life setting. The comprehensiveness of clinical immersion provided an unusually rich perspective on to the day residues, i.e. the preconscious preoccupations with which the dreamer dealt. This perspective was far more detailed than that in any study I have come across in the published literature, the majority having relied on volunteer respondents seen outside of a treatment context (**Hartmann 1984**, **Hersen 1971**, **Van der Kolk 1984**).

For purpose of the present investigation of chronic post-traumatic nightmares, I am calling *chronic* any nightmare occurring more than

two years after the initial trauma, and *post-traumatic* any nightmare identified by the dreamer as being *about a* traumatic experience that actually happened. Hence, even if a dream scenario, on detailed examination, proved not to be about e.g. a battlefield experience, that nightmare was designated 'post-traumatic' if the patient identified it as replaying a traumatic event. 15 of the 40 nightmare sufferers were post-traumatic using the above criterion.

III

These nightmare sufferers had chronic post-traumatic nightmares containing a recognisable traumatic event that had occurred years, usually decades, previously. Most, but not all of the patients, were non-psychotic. Virtually every one of the traumatic nightmare sufferers had easily identifiable, gross and continued dysfunction in the families in which they grew up. The vast majority of those who were combat veterans with post-traumatic nightmares had volunteered for combat. There was also gross dysfunction in the current familial relationships or alienation from current family or family of origin when the patient was an adult. The latter finding, of course, must be considered in the context of a patient population disturbed enough to require psychiatric hospitalisation, usually more than once.

I shall discuss the clinical material with emphasis on the processes of distortion involved (especially secondary revision), global familial dysfunction in these patients throughout the life cycle, chronicity of the nightmare, and the screening function of chronic post-traumatic nightmares.

Secondary Revision

Of particular note is the fact that the nightmares, though described by the dreamers themselves as a re-experiencing of specific traumatic situations - that is, almost as a charged night-time memory rather than a true dream - were, in this sample, never simple 'replays' of upsetting experiences. They were infiltrated with material from

childhood or adolescence or with current concerns. They were usually so constructed that the patient was attacked rather than attacking in the dream scene, i.e. aggression was projected. In some instances, battlefield scenes were present in the nightmares even though the patient had not been in combat.

The fact that patients *experience* dreams as though they were flashbacks or simple memories of the trauma is noteworthy enough to warrant discussion. Patients would describe as re-experiencings of battlefield situations nightmares that had nothing to do with the battlefield. Some had obvious origins in the early familial situation. Some patients who were never in combat had dreams of battlefield situations. The patient's surprise at interview, on realising that these post-traumatic dreams were obviously much more complex products of the imagination, must be seen as an aspect of disguise, a type of *secondary revision* added on to the patient's recollection of his or her experience of the dream for the purpose of keeping the experience from being too troubling and too much a part of the patient's ongoing and disturbing psychic continuity.

Freud identifies secondary revision as part of the dream work done by preconscious, not unconscious processes (**1900**, p. **499**). Secondary revision consists of an afterthought or judgement about the dream itself, for example, 'it's only a dream' or, in the sample here described, 'It's a replay of what happened to me'. Secondary revision is the line of defence used when distortion by displacement, condensation and symbol formation fail to dampen the disturbing impact of the dream. Such secondary revision '… appears in a dream when the censorship, which is never quite asleep, feels that it has been taken unawares by a dream which has already been allowed through. It is too late to suppress it, and accordingly the censorship uses these words to meet the anxiety or the distressing feeling aroused by it' (p. **489**). 'Secondary revision' in the topographic theory of 1900 was an early conceptualisation of what would later be subsumed under the activities of the ego.

One patient regarded his nightmare as having nothing to do with upsetting experiences in his life.

Example I

A 36-year-old man stated emphatically during the interview that his nightmares, suffered since adolescence, had nothing to do with upsetting experiences in his life. (Accordingly, by our narrow criteria for post-traumatic nightmares, his nightmares could not be classified as post-traumatic in our study.) He had been admitted for a host of problems which included spouse and child abuse. Nonetheless, he related a recent nightmare that had an obvious relationship to a traumatic event:

> I went to sleep about 1.00 a.m. I dreamt I went to my front door to answer it. A man blew my head off and then my wife shot him. The man's face was like a blank page. I awakened sweaty with my heart beating fast. I was frightened.

Later in the interview, discussing his military experience, he described a horrifying event that he said had taken place in boot camp.

> A fellow soldier, a homosexual, jumped into bed with me. I grabbed him by the neck and threw him out. I guess he was to be arrested. The next night he came back with a gun to get me. My (best) friend R pushed me out of the way. R was killed. We had enlisted together as buddies. I had amnesia for the whole war experience. I didn't even get to his funeral. I still have nightmares about it (18 years later).

The nightmare replayed the trauma in the barracks but with a number of striking modifications. The murder is relived but this time *the*

patient, rather than R, is killed. The dream work deals with his guilt over his friend's death, over the physical abuse of his children, over his homosexuality and over his longstanding hatred of his parents stemming from his being abused during childhood. *The attacker had a blank face. As* was the case with his amnesia for events after R's death, he cannot allow himself to be specific concerning the traumatic scenario that would upset him too much. The dream emphasised that *he is married*, i.e. the dream work tries to obviate the issue of homosexuality in the barracks. *His wife kills his attacker.* This element deals in modified form with his reactions to the cruel beatings received by his father and his overly strong attachment to his mother, but also his own guilt feelings for abusing his children with the fatal act of justice accomplished on himself - as the man with the blank face - at his wife's hand. In the nightmare his propensity for violence is projected: *everyone is violent except himself.*

The patient's insistence that his nightmares had nothing to do with his life experience is a quite striking example of secondary revision, that is, a conscious afterthought on the dream used to dissociate the dream experience from integration with the entire continuity of his life: his childhood, his military experience, and his current familial difficulties - all of which had to do with uncontrolled and sexualised aggression. Another patient told himself that his nightmares were 'about the war.'

Example 2

A 41-year-old black man with a history of cocaine abuse and numerous prison sentences reported the following nightmare.

> I was being held prisoner by a bunch of guys, I don't remember who exactly. I was chained to a wall while they prepared instruments of torture. The torture never took place as I realized it was a dream. I tried to escape from the dream and awoke.

He recalled having the same nightmare around 3:00 am. every few months since he returned from Vietnam at the age of 20. He had suffered from nightmares since the age of 12.

His view of the nightmare was that it was a dream of an actual scene of being held prisoner in a prisoner of war camp. He elaborated.

> I'm always in this compound, either put in tiger cages or staked to the ground or carried on a pole with my hands and wrists tied. I got beaten. I always wonder how I could withstand the pain. I awakened yelling.

He had at first attributed the nightmare scenario to his combat experiences but, when questioned, he acknowledged that he had never been imprisoned in Vietnam. Questioned about his childhood, he gave an account replete with family strife: alcoholism, abusiveness and violence by his father. The father would drink himself into a fury so much so that the patient would feel terrified if he saw his father's car at home when he returned. Father, when in rages, beat his mother and all the children. At other times he would tie the patient and his brother to stakes, whipping them mercilessly. In the midst of these beatings, he would take breaks and calmly smoke a cigarette before picking up the whip and hitting the boys again. His mother did nothing to protect her children, and the patient realised only in high school that other families were not like this.

As the patient became aware of the obvious relationship of his nightmares to his early familial experiences, he became profoundly shaken. His cocksure and slick façade collapsed almost immediately. and he was visibly agitated and upset. The day following the inteview. he requested a brief pass from the ward, claiming that he had an appointment with his parole officer. He did not return, and the ward received a phone call the next day from the parole office informing them that the patient had produced a urine specimen positive for cocaine and was imprisoned immediately. The insight provided by discussion of his nightmare about his eroticised childhood abuse made it clear that his engineering his own imprisonment on the day after the nightmare interview was an acting out in which he engineered an imprisonment. an experience very much like the one in the nightmare. This episode of acting out served to replace his devastating remembrances of childhood abuse with an actual imprisonment.

Dysfunctional Families

Lidz **(1946)**, describing a sample of acute post-traumatic combat soldiers, reported the ubiquity of dysfunctional families, that is, predispositions to traumatic neuroses (see also **Moses 1978**) in the histories of his patients. He also noted hatred of the same sex parent and suicidal wishes, and observed considerable evidence of dream work in acute nightmares evidenced, for example, by the patient's wishes to attack portrayed in the dream scenarios as attack on the patient. Many of our patients (Lansky & Karger) reported severe early familial dysfunction (13 of 15 or 86.6%) and upsets contemporaneous with the time at which the trauma occurred, e.g. death of a close buddy, 'Dear John' letters from a girlfriend (six of six questioned, 100%). (Questions about narcissistic wounding contemporaneous with battlefield trauma were begun after the study was under way. Hence the small proportion of the sample questioned.) These narcissistic wounds contributed to these persons' greater experience of traumatic damage compared to others exposed to the same battlefield trauma. Our sample, then, suggested a view of the origin and nature of post-traumatic nightmares similar to that of Lidz, i.e. that these nightmare experiences were very much dreams in the true psychodynamic sense.

The following case illustrates traumatic familial dysfunction, past and present, utilised by the dream work in nightmares involving combat situations.

Example 3

A 44-year-old man with dissociative states in which he cross-dressed had the following nightmare after an angry exchange with his resident physician who had just set his discharge date.

> It was as if somebody was telling me that they were going to get me or kill me if I didn't get them first. Vietnamese, two men

and a woman, that I actually killed. Then I woke up and found myself cross-dressed.

Exploration of his early family life revealed a devastating pattern of abuse and traumatisation. His mother had brought home numerous lovers and had had intercourse with them with the patient present. He was not able to tell his father about mother's activities until she deserted the family when he was nine years old. He had felt disloyal to the father and unable to approach him. The patient's dissociative episodes in adulthood followed situations in which one might have expected him to feel anger.

In the dream itself he felt no anger but only the persecutory fear that the Vietnamese might get him. The anger is, of course, implicit in the dream text; he had killed the people who, re-embodied in the dream, were seeking vengeance. When he awoke crossdressed, he felt rage at his doctor for setting a discharge date and fear of his anger. His current hospitalisation provided the first opportunity that he had ever had to feel anger in an environment that he saw as supportive enough to tolerate his emotional turbulence. His acknowledgement of rage in the therapy situation helped him to acknowledge his rage at his mother's sexual escapades, her involving him as a witness, and at his traumatic and neglectful upbringing in general. Soon the rage replaced the dissociative episodes during which he cross-dressed, and the anger became available for his work in psychotherapy.

This patient became extremely interested in his inner life following his therapy and the nightmare interviews. A second nightmare interview was held at his request about a month after the first. He reported the following nightmare.

> I've gotten sprayed in the shoulder with shrapnel. We'd been evacuated out of a combat area. Vietnam or somewhere. Everybody got on the plane. After we took off, my daughter wasn't on the plane. She was in the nightmare. My wife was there too. So were several (he named three female) staff members. Other nurses. When we got ready to take off, one guy said, 'What about these wires?' I said, 'Yank them out.' Took all of the food out of the house. My daughter was locked out of the house trying to figure out how to get out. I got sprayed by shrapnel - face and parts of the shoulder. Then we were in some kind of a depot. I was taking in dirty linenpajamas and linen. A short, petite girl had a pair of shower shoes on four sizes too big. More rounds came in on us. My daughter got hit, then I jumped out of bed.

He had said that this was just like a dream the week before. It also involved his daughter. He was able to identify his physical pains in the dreams as actual feelings from shrapnel wounds that he had received. He had several more nightmares in which his daughter was killed.

After an exploration of details in his current life circumstances, it became increasingly clear that after he had left the hospital and gone home there had been a good deal of tension in the family on his return. His 11-year-old daughter, who had had all of her mother's attention while the patient was hospitalised, became jealous. He went through a good many episodes of her appealing to her mother, interrupting intercourse, and in general attacking the couple's privacy. Although the patient did not feel conscious anger at this intrusiveness, he (as author of his dreams) included her in the battlefield scenes in the nightmare and killed her in several different nightmares. Discussion of the dream details enabled him to acknowledge his anger at his daughter without confusing that anger with the rage he felt in response to the early familial situation which had so overwhelmed him.

Chronicity

Some of our data served, however tentatively, to suggest some explanation of the *chronicity* of these nightmares. If the natural history of post-traumatic nightmares is such that these nightmares usually become diluted with other dream elements and disappear in a matter of weeks to months as true nightmares **(Hartmann 1984)**, why do nightmares in these patients remain repetitive and chronic for decades?

It is likely that many factors contribute to the chronicity of these nightmares. In an attempt to approach the problem of chronicity, I draw upon the idea of a confluence *of* determinants other than the specific traumatic event portrayed in the

nightmare. By determinants, I mean not only pre-existing concurrent and subsequent personality vulnerabilities that may have been traumata in themselves, but also coexisting traumata - usually from early life - find expression in the dream text (Examples 2-7).

The nightmares seemed clearly to have a screening function for infantile trauma and its residua. Most of these patients were raised in families in which marital strife, violence and alcoholism were rife. Frequently, the patient not only overtly hated his father or his mother's lovers, but attempted to attack or kill that person.

Example 4

A 38-year-old man was admitted rageful and depressed, claiming that wartime experiences had damaged him and that the government had not taken care of him and compensated him properly for the damage done. He reported several nightmares that were typical of those he had frequently since 1970 when he was 19.

He described one as follows.

> A fire fight with a Viet Cong. A constant shooting and killing. I was running, falling on my belly, excited and scared of being killed. I woke up throwing up and sweating.

At a later point, when he described his family of origin, he recalled beatings by his father that occurred repeatedly and with no

protection from his mother who left the room when father went into a rage. Both parents were alcoholics. As he described these terrifying attacks in his early family, it became clear that he had experienced a virtually identical state of mind then as he had in the recurrent battlefield nightmare. He levied the same charges of being damaged and not cared for at the government as he did at his parents. Although it was clear that the battlefield trauma and the childhood trauma were indeed separate matters, the consciously felt rage at and demand for recompense from the government gave him the opportunity to express concretely his sense of being damaged, frightened, attacked, and to act on his fulminate sense of entitlement deriving from a sense of early life injury. He felt more convinced that he deserved better treatment from the government than he had felt in childhood about his parents' treatment of him. The nightmares served to concretise his state of mind, the helplessness and terror that were common to his childhood and the battlefield - the latter screening the former.

The same patient reported another recurrent nightmare, variants on a scenario that actually occurred.

> I have an almost constant vision of a man that got killed in my place. He went on a mission I should have gone on. I see a floating head full of bullets or C being shot and being blown 15 feet in the air. In another scene he was calling for his mama. With the bullet holes, he looked like Jesus Christ with the crown of thorns. My pain (from a wound sustained at that time) was very evident. I was tough on him. He looked up to me.

The patient reported numerous variations on this nightmare and the feeling of intense guilt that the younger soldier whom he had disciplined harshly but who had idealised him died on a mission on which the patient felt he should have been sent.

The sense of guilt and determinants went back to his (conscious) childhood hatred of both parents, especially his father. In his current family situation, his guilt had a contemporary source that added to his childhood and young adult conflicts. His marriage had collapsed after his wife decided that his self-absorption, rage, and

difficulty functioning in the family were intolerable. He became painfully aware that he could not tolerate his children getting close to him and he felt, to his horror, that he had become just like his father. The nightmare of the younger man's death and the sacrificial injury and subsequent feelings of guilt screened the sources of this sense of remorse by relocating it to the battlefield 18 years before and employing a recollection in which the actual injury done to the younger person was by enemy forces rather than by himself.

In addition to overt hatred of the father, there was terror at the father's violent methods of keeping tenuous control in a strife-ridden household, and also contempt felt for father's alcoholism and vocational failures. These factors combined to leave lifelong residua which served to generate further failures in interpersonal and vocational functioning. The lifelong (conscious) feeling of rage at father or mother's lovers was easily elicited by simple questioning. In addition to the rage, however, was a contempt for parents and a crushing sense of shame concerning the entire family. At an unconscious level was a shameful sense that the patient had of himself, resulting not only from his hatred of one or both parents, but also in large part from his unconscious identification with a man held in such contempt and only poorly captured by the phrase ‘low self-esteem’ **(Greenson 1954)**.

Example 5

A 43-year-old man recalled the following nightmare experience.

> I have trouble knowing what my dreams are because they are multiple dreams. That night it was about my past. I was starting to awaken when the ward nurse checked on me. I woke up feeling very guilty, thinking this dream, like many, was about the fact that I miss a girlfriend that killed herself. I still take a lot of responsibility. The rest of my dream I felt very scared. I felt that I'm asleep, she's either next to me or trying to get in my apartment. It's so real, I'm fully carrying out a conversation with her. At the same time, there's lots of anger. (He notes that a second girlfriend killed herself, too.) She's calling to me. Don't do this to her. I'm leading her on. She was asking me to help her. Why didn't I love her. In the dream, I was with the first one. (He recalled thinking about the losses a lot in the past.)

Curiously, he said that he had called this a nightmare because he wanted to kill himself. The events in the dream scenario actually happened. One girlfriend had committed suicide two years prior to the time of the nightmare and another three years before that. In the nightmare, a desperate scene is replayed concerning a girlfriend who subsequently killed herself. It is a small inferential step to presume that the action in the dream as well as the patient's feelings of guilt and anger derive from his murderous wishes toward the woman. But the nightmare, with its evident rage and deliberate destructiveness towards the women and his conscious guilt and rage, resonated also with his disruptive and traumatic childhood. He had been born into a chaotic family. His mother was in a psychiatric hospital when he was born. Both parents were alcoholics. His father had beat his mother repeatedly. His brother and mother had locked the patient up in a basement when he was very young, and the brother had molested him sexually. The father punished the patient sadistically with a phone cord and at one time abruptly sent him away to live with relatives in Mexico. The patient had had a sexual liaison with a housekeeper whom he later found out to be his half sister. He had spent some years as a homosexual prostitute. He carried with him (conscious) fury at both father and mother for the violence and chaos in the home.

Although this man clearly identified his nightmares as concerned with traumatic

experiences, he felt that those experiences were the two women's suicide and did not, at first, recognise that the rage and guilt derived from his childhood, nor that the triumphant and sadistic conscious withholding of love was indeed a reversal of what was done to him.

The helplessness and fears of attack on the battlefield have strong resonances with early familial environment. Traumatic dreams screened these early experiences in many ways. Noteworthy among these is the actual staging of the dream setting on the battlefield (Examples 3, 4, 6, 7). While the nightmares *generated* terror - a manifest reaction to the attack, they *modulated* or diminished very powerful affects of shame and rage, very prominent in the patient's legacy from early familial traumata and consciously felt virtually all their lives. The patients not only felt these strong affects but also had continuing problems in life outside of the family with the sequelae of unacknowledged shame (Lewis **1971**, **1987**) and rage, either unexpressed or expressed with disastrous consequences in inappropriate places and in ways that made workable vocational and familial adaptation tenuous or unattainable. It seemed as though these patients' senses of shame derived in large part from their identifications with parents of the same sex who were not only the object of their hate but were also objects of contempt **(Lansky 1985)** and a major source of their contempt for themselves. While fear was the major (and even defining) affect in the nightmare, the shame and rage so operative in the patient's waking life are diminished (Examples 1, 2, 3, 4, 5). The setting of the nightmare, then, served the defensive function of revealing the basic childhood fears in a setting in which both unacknowledged shame and uncontrollable rage were neither operative nor problematic. The *justification* of fear and sense of attack provided by the battlefield scenario and the *elimination* of the patient's preoccupations with unacknowledged shame and uncontrolled rage - lived in the immediacy of the dream experience - can be looked at as a compromise formation that reveals fear and conceals shame and rage, and hence, as a representation of the unconscious wish to transpose these emotions as fulfilled.

This line of thinking gained support from a number of other findings. First, the vast majority of the post-traumatic nightmare sufferers (ten of eleven questioned) volunteered for combat. This selection of combat veterans was emphatic about wanting to serve in combat for personal, not for patriotic, reasons. That is to say, being in the combat situation was their *specific and conscious wish* prior to the experience of combat replayed in the dream. The reappearance of the battlefield scenarios may be presumed to represent *the same constellation of unconscious wishes that determined the conscious choice to volunteer for combat*, i.e. the handling of intense shame and uncontrolled rage by removing oneself to the battlefield where the sources of shame and rage are neutralised or rationalised by the battlefield situation. A high percentage of narcissistic wounds such as buddies dying in battle or 'Dear John' letters received from girlfriends has been pointed out by Fox **(1974)**, who noted reactions of rage rather than grief in soldiers whose buddies died in combat, and by Lidz **(1946)**. It was also high in our sample (100% of six patients questioned). Such narcissistic wounding is one source of shame and rage. The legacy of early familial trauma is undoubtedly a greater source of shame and rage. Examination of these patients' current familial functioning or lack of it opened up another confirmatory avenue of thinking; that is, that the nightmares also screen shame (often unacknowledged) and rage in current family or other relationships. Alienation from family of origin (thirteen of fifteen, 86.6%) or dysfunction in family of procreation (fourteen of fifteen, 93.3%) contemporaneous

with our investigations was widespread. One patient (Example 4) reported his shame over the fact that he could not tolerate his children's approaching him. Another (Example 3) had a nightmare in which his 11-year-old daughter was killed in a raid.

One patient who was brutally abused as a child expressed suicidal wishes, first in nightmare, but later quite consciously, and related these to his horror and humiliation over his continual physical abuse of his wife and his children. His suicidal wishes were directly related not only to his guilt about the violence, but his shame at having become like his own father whom he had seen abuse his mother.

Example 6

A man in his late forties who was admitted for a combination of difficulties, including depression, alcoholism, spouse and child abuse, reported the following nightmare.

> I was in the Marines, fighting in my hometown. There were gang members. In my dream, I was at my house (in a small town about 100 miles from Los Angeles). Across a big truck line. My adrenalin's really flowing. I'm back where I belong. There was this 17-year-old 'baby' who got shot. I laid him on a table. I said, 'My wife's a nurse'. He was shot in the groin on the right. I blanked out in a nervous state. I felt good. I was back in the military again. I was a platoon sergeant again. I'm important. After seeing this kid get shot, I felt I could have done more. I felt mad. I let him get shot. It could have been prevented.

He went on to discuss his fears in the dream with a sense of shame as though he were admitting cowardice in a real-life situation. In his account of another dream, in which he was having intercourse with a woman other than his wife, he talked as though he were discussing an actual act of adultery.

The relationship of the dream to this man's traumatic past and upsetting current familial situation was complex. He himself had come from an abusive family where he was neglected, beaten and deprived. He had felt that his mother had wanted to get close to him but his father would not allow that to happen. His mother would have wanted to have left if she could but she was afraid. In his own family, he ruled tyrannically and by force, orchestrating down to the last detail the conduct of his wife and five children. When he was employed, he worked as a trucker and was frequently away from home.

The dream dealt both with fear in his original familial situation and as reliving the fear that he had at the age of 17 when he enlisted in military service to escape the drudgery and depression of his adolescent existence for the exhilarations of the battlefield. This man was so unable to acknowledge fear that he felt he had to account for his cowardice when he felt helpless and afraid experiencing the nightmare. He could allow himself to feel fear for someone else's safety. The dream which took place in his current home town also expressed his death wishes toward his children (displaced onto the enemy) and his extreme guilt at being unable to prevent the harm he had done them. To his horror he had turned out very much like his abusive father. The dream also revealed the wish carried over from adolescence (i.e. with himself as the 17-year-old) to be killed and to make his father upset, sorry and wishing he had done more.

The nightmare, which he identified as one of many dreams related to upsetting experiences in his life, dealt in a complex way with his unacknowledged anxiety, his overwhelming guilt, and his feeling that he was unworthy to continue living both because of his early hatred of his parents and because of his current abusiveness to his family. The restoration of an exhilarated mood state, easily identified by the patient in

the nightmare, had been an important motive for the patient's choosing a combat career in the first place. At the time of the interview, he voiced both the wish to return to the exhilaration of the battlefield - he wished he had the opportunity - and to be killed as a hopeless and unworthy head of his family.

These lifelong difficulties in interpersonal relationships, resulting from overwhelming shame as a legacy of family of origin and pathological identifications with the same sex parent felt to be contemptible, *generated further and almost continual psychic trauma in adult life.* Such trauma was further represented by terror and the feeling of helplessness and aloneness under attack, and explained by the battlefield situation and the justification and identity that comes with the combat soldier's role. Thus continuous and recurrent traumata resulted from the interplay of shame and rage in self amplifying spirals **(Scheff 1987)**. These were evident from the ward observations and studies of current family and provided an almost continual day residue that was a further stimulus for the nightmares.

Screening

The function of the chronic nightmare in screening current familial difficulties was further confirmed by the manner in which these patients described their need for treatment. One patient (Example 4) appeared on the ward, rageful, demanding justice for his war injuries, and claiming that the government was unfair. His threats and demands and sense of entitlement were put forth with great bluster and selfrighteousness. He demanded redress of unfairness received and damages done on the battlefield. Only later could he admit that his marriage had failed and that, despite his love for his children, he could not tolerate their approaching him. Even later he recalled shame and terror as a boy, watching scenes of brutality in which he saw his father beat his mother. The fact that his waking mind split off his battlefield experiences from his familial ones and intensified attention to the former at the expense of the latter again supports the presumption that the dream scenario directs attention from shame and rage in the familial settings past and present, and that the nightmare's placing of the patient back on the battlefield where shame and rage at love objects is replaced by (unacknowledged) fear is a representation of a wish as fulfilled.

In *this* sample then, the chronicity of the nightmare seemed to be the result of an overdetermination by a lifetime of traumata. All this could be represented in the nightmare scenario, albeit at the cost of the generation of overwhelming fear and helplessness. The gain accomplished by the dream work was modulation of pervasive feelings of shame and the rationalising of the uncontrolled rage resulting from shame that is unacknowledged in the patient's current circumstances. What has the surface appearance: of a simple replay of a scene to which intense helpless fear is an appropriate response (that is, an emotionally charged memory, a night-time flashback to the battlefield) *also* has the screening function of defensively distorting the continuous and perhaps more painful affective sequelae of infantile and adult traumata in such a way that shame and rage are dampened in an attempt to preserve the equilibrium of the psyche during the regressive relaxation of sleep.

These points are illustrated by the following example:

Example 7

A 32-year-old man was admitted 12 days after the murder of a friend who was sitting

next to him in a car. The patient gave a somewhat evasive account of his connection with the deceased. He referred to him alternatively as ‘my partner’ and ‘my friend’ and described in a confusing way his efforts to locate this man in the weeks preceding the murder. His ‘partner’ was well to do but apparently was not regularly employed. The patient had recently been discharged from an alcohol rehabilitation program and was without funds or a place to stay. It seemed to the interviewers not unlikely that this person was a drug seller.

The patient's account of what happened was as follows: he and his friend were in a car going to get a drink when a car pulled up. There were three or four shots. The friend died instantly, slumped toward the patient who slid down in the seat, opened the door and ran. The patient apparently had a fugue state, awoke in a psychiatric hospital, left after a few days and was readmitted to another hospital.

He said his nightmares were exact repetitions of the upsetting event and that they had occurred every night since the shooting 12 days previously. He gave two versions.

> He was in his friend's car. *A woman came up with a gun and called him by his first name (a* very unusual one). She shot his friend.

The second version:

> He was in the friend's car. There were three or four shots. The friend slumped over. The patient got out of the car and ran (the actual event). He *stumbled.* He ran and fell. It was dark. He ran off a cliff or onto a body of water. The fear of falling woke him.

He recalled that he first started having nightmares at 14 when his baby half brother had just died. At the time when the child was terminally ill the father, running to telephone the doctor, *stumbled*; the baby was dead by the time the doctor arrived. The patient recalled conscious resentment of the new child who was the only child of his mother's and stepfather's union and hence (he felt) supplanted him. He recalled, 'I messed up to get attention', especially from his mother. The interviewer asked if he felt that his parents were angry at him. 'Yes', he replied, 'especially my mother'. The interviewer noted that the woman in the dream called him by his first name (a quite unusual one) and shot the other man. The patient added that only his mother calls him by that name. The interviewer noted that in both the recent situation and in the earliest nightmare when he was 14, there was reference to a male more favoured than himself who had died in his presence, a recollection of someone stumbling and running away. The patient then had recollections of his family: his mother was unfair to him; she blamed him for everything; he had carried around conscious rage at her since the age of four; he resented his half brother's birth; he was ashamed both of his resentment and his neediness; he lived in fear that he would be blamed for those angry feelings.

The dream then co-mingles the traumatic situation, the death of his accomplice, with the earlier death of his brother. The latter occurred right at the age his nightmares began. The dream work by substituting the mother for the unknown recent assailants brought his fear into the more predictable family situation. It was his mother's wrath over the feelings about his half brother's death that was to be dealt with rather than the more uncontrollable and incomprehensible shooting of his accomplice.

Despite numerous evidences of dream work linking the current trauma with the death of his half sibling at the age of 14, this patient thought that this recent posttraumatic nightmare was an exact repeat of the traumatic scenario.

The screening function that Freud **(1899)** first described for memories, screen memories, was described as memory in which unusual vividness accompanies a

surprisingly bland content, the elements of which proved analysable, much like that of a dream into a latent content which was much more conflict-laden and upsetting.

Freud's paper came near the end of the period where his central focus was on trauma and its reconstruction, so he did not elaborate the concept of screening further than these unusually vivid, but bland memories, that could screen experiences earlier or later. Nonetheless, the concept of screen memories remains a major aspect of psychoanalytic thinking. Glover **(1929)** pointed to the screening function of traumatic memories which may serve to express, but also to conceal, even greater traumata, citing a case of a traumatic circumcision screened by a hand injury.

The following case illustrates the screening of the experience of an emerging psychosis that was contemporaneous with a battlefield experience which was represented in a nightmare.

Example 8

A 33-year-old, hospitalized schizophrenic combat veteran reported the following nightmare at age 20 in combat.

> There were rocket attacks in Cam Rahn Bay. I was asleep. They rocket attacked the base. A room of four people. One got torn completely out of his boots. Pieces everywhere. Blood. I dream I find his face. In my bed. He's trying to talk to me. (Interviewer asks if he were close to this person.) Yes. All four of us were real close.

This nightmare recurred three or four times monthly for 13 years up to the time of the interview. The actual scene did not occur as represented in the nightmare, but he did see people killed with pieces of their faces gone.

He described an uneventful childhood. In the military technical school in 1970, he received a 'Dear John' letter from his fiancée, became suicidal and volunteered for combat with the (conscious) hope of being killed. After several months of combat in which he saw a great deal of surprise attack, killing and dismemberment of close friends, he had an overt psychotic break and was hospitalised and evacuated back to the United States. Nightmares began after his return home.

When the events contemporaneous with his combat experience were explained, it seemed plausible that his recurrent nightmare chronicled and reworked not only his horrifying combat experiences but also- in allegorical fashion- his emerging shattered sense of self and unfolding psychosis.

I am here applying a line of thinking inputting the same screening functions to nightmares as Freud did to vivid memories. Explanation of their screening function may contribute to an understanding of the endurance of chronic post-traumatic nightmares as well as of their affect-regulating function. There were very few acute post-traumatic nightmares in the study. I assume that many acute nightmares may be more like flashbacks or night-time intrusive memories, and that this screening function may have been superimposed on the acute nightmare. Further, these numerous sources of traumata - from earliest family of origin to the time of the inquiry provided a rich overdetermination for which the original albeit modified scenario served as a screen. That is, the patient's regarding of the nightmare as though it were an upsetting but basically undistorted memory is in itself an aspect of secondary revision that is part of the dream work, a method of concealing the expression of conflicts resulting from adult and infantile traumata that resonate with the battlefield scenario.

Conclusions from these data should not be overgeneralised. They do not shed light on the problem of how or why certain traumata generate nightmares. The data concern the chronic, not the acute phase of the nightmare's natural history. Caveats regarding the specific sample are worth repeating: the sample is one of *chronically psychiatrically impaired inpatients.* This is an exceedingly disturbed

population that differs greatly from populations used in other studies (**Lidz 1946**, **Hersen 1971**, **Van der Kolk 1984**, **Hartmann 1984**) and the traumatic scenario usually dated from one to more than four decades prior to the nightmares being studied.

Needless to say, noting the screening functions of the chronic nightmare is not meant to imply that the battlefield situation does not generate severe and lasting trauma. It has been my overall impression that the actual exposure to combat, the risk of attack, maiming and killing, having close comrades die and exercising one's own aggressiveness by deliberate attacks on others (no matter what the justification) exerted a permanent and virtually irreversible effect on these men's psyches. Detailed elaboration of the nature of battlefield trauma extends beyond the scope of this paper. Such experiences were perhaps more damaging in cases where inchoate and unmanageable rage at family members had been present prior to the combat experience.

The case material points convincingly to the usefulness of considering chronic post-traumatic nightmares to be dreams in the fullest psychoanalytic sense. Freud began ***The Interpretation** of Dreams* (**1900**, p. 1) with the claim that: 'Every dream reveals itself as a psychical structure which has a meaning, and which can be inserted in an assignable point in the mental activities of waking life'. The sample of post-traumatic nightmares provided a venue for the re-establishment of a sense of continuity in these patients' lives. Despite the terror, the unpleasantness represented and the fact that the patients' sleep was disturbed, these nightmares do not require a major revision of our understanding of dreams. Although the task of preserving sleep - a major function of dreams - has failed, an understanding of the specifics of the dream work points clearly to affect-modulating activities. If experiences of shame, isolation and rage can be thought of as more disturbing than the experiences of attack and comprehensible fear represented in the nightmare, then the dream work, by screening the former experiences by the latter, serves to modulate affect and to attempt restoration of psychic equilibrium rather than to generate anxiety and promote disorganisation of equilibrium. Patients' experiences after awakening were often of a sense of overwhelming shame and uncontrollable rage that became more accessible to psychotherapeutic amelioration when the dreams were utilised psychotherapeutically. In some way, the battlefield scenario embodied the wish to be out of their current (unmanageable) interpersonal circumstances and on the battlefield where their affective storms, paranoia, unmanageable rage and poor sense of their worth among intimates, made more sense than in their current families or relationship systems. The presumption of such an unconscious wish gained support from the fact that most of these patients made the conscious choice to volunteer for the combat situation that was represented in the nightmare. The dream work is evident in virtually every dream. Many features of the dream work are embodied in the screening function of the nightmare.

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