interrelatedness of our private intrapsychic and public interpersonal worlds.

In summary, 'politics' has to do with power and the distribution of power – and so do dreams. By focusing on our dreams and our imaginal life we come to know our own personal power; we are empowered. In our dreams we experience the personal face of political issues. Through the power of the dream image and dream work, we can effect social and political change in the world. In these ways dreams are political.

It is important to remember that the word political comes from the Latin 'polites' (citizen), from 'polis' (city). Only if we care for and take responsibility for our inner citizens, our ailing, marginalised, mistreated, oppressed soul figures, and only if we take responsibility for our inner cities, our neglected, troubled, beleaguered imaginal spaces, can we be full citizens, truly responsible citizens of the 'polis' and of the world community.

Posttraumatic Re-enactment in Dreams

Bas Schreuder

It is well-known that if you have been subject to a traumatic event, whether you are the victim of a rape or an assault or a second world war concentration camp survivor, chances are that you will live through the traumatic events again during the dreams you have. These bad dreams. which may cause very considerable distress, we usually call nightmares.

It is now argued that what are generally designated as 'nightmares' are, in fact, two very different phenomena. A distinction should be made between nightmares proper and, on the other hand, nocturnal re-enactments of psychotraumatic experiences.

What happens during such a posttraumatic re-enactment is illustrated by the Polish author Póltawska who has described the symptoms in Jewish children who survived Auschwitz where they were at ages six to twelve. According to this description, recollections come to the fore suddenly and violently 'which do not take the shape of thoughts, but of images, scenes, sometimes a sequence of scenes that these people went through. The memory then starts to reproduce the mental impressions felt earlier, such as the entire atmosphere of the scene which they

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lived through in the past; the noises they then heard; the smells as well as the tactile sensations from those times. These recollections are so realistic that the erstwhile prisoner is under the impression of experiencing all this afresh. This impression is accompanied by vegetative symptoms: a sudden paling in the face, tachycardia (increased pulse rate), trembling, sweating . . . The fear is sometimes so intense as to bring about physical activity in the form of jumping up, running away, pacing up and down the room. The fear does not become less intense despite the fact that the reality check of the person enduring this is undamaged.' (Póltawska, 1967)

What is striking here lies in the description of the way these psychotraumatic experiences are recollected. Thus, the people. the scene and the sequence of the events in the dream content correspond perfectly to the people, the scene, and the sequence of events as they occurred in the psychotraumatic experience. Whatever happened in the past, an exact replication of the event is found in the dream. The dream does not assume the shape of a film that is being watched by the dreamer; it is a film in which the dreamer himself appears as an actor.

This now is very different from what happens in nightmares which occur, particularly, during the second part of the night, during the so-called REM sleep. REM stands for Rapid Eye Movement, which is characteristic of light sleep. According to Hartmann, in *The Nightmare: The Psychology and Biology of Terrifying Dreams*, nightmares are long, terrifying dreams from which the sleeper awakes. Part of this general category are the posttraumatic nightmares in which the dream content refers to the traumatic experience. But contrary to re-enactments, processes of condensing content are at work and there are incongruities in time, place and persons. Thus, while the dream scenario corresponds with the traumatic experience, the people featuring in the events, the scenes and the time sequence of the events may be subject to condensation. For instance, people from the sleeper's present may appear in the nightmare.

In other words, the clinical manifestation of the posttraumatic nocturnal re-enactment clearly differs from the way in which the posttraumatic anxiety dream or nightmare manifests itself.

Physiological Findings

In order to find out more about what exactly happens during the time one is asleep, the EEG is employed. Electrodes are glued to various places on the scalp which then measure the 'brain waves' by recording differences in electric potential. Polysomnographic data, including sleep EEG changes, are linked with parameters such as heart rate, blood pressure, motor activity and skin conductance. From these EEG data it has been found that sleep is characterised by sleep cycles of about 90 minutes in which the sleep depth changes. This is reflected in the oscillation of REM and Non-REM sleep stages and in the total amount of REM sleep. In adults REM sleep dominates the second part of the night and is related to dream recall. Three questions are now relevant in tracing the differences between posttraumatic nightmares and posttraumatic re-enactments.

First, it is asked in which sleep stages the posttraumatic re-enactment occurs. Several studies indicate that nocturnal

mental activity referring to psychotraumatic experiences does not occur in REM sleep only. Rather, this activity is also found in several phases of Non-REM sleep.

The second question involves the biological arousal and the reaction of the autonomic nervous system during a posttraumatic re-enactment. The autonomic nervous system is responsible for the rise in blood pressure, the increased pulse rate, and the excessive sweating which are seen during the posttraumatic re-enactment. But the intensity with which these arousal reactions take place, as well as the severity of the autonomic reaction do not, remarkably, belong to the set of phenomena related to the REM nightmare. In the case of the REM nightmare there is a gradual increase in pulse rate with a lower maximum, and moderate autonomic arousal.

Third, a posttraumatic re-enactment shows complex motor activity. Often, this activity was found during Non-REM sleep. which is congruent with the fact that then there is no inhibition of the motor system. But in some cases it was also found during REM sleep. This doesn't correspond with the fact that atonia of the muscles occurs in REM sleep. The way complex motor activity occurs during posttraumatic re-enactment agrees with the description of REM sleep behaviour disorder. associated with inhibitory failure of the motor system.

The clinical descriptions given above, as well as the sleep physiological findings given here make clear that there must be another form of nocturnal mental activity in which psychotraumatic experiences are relived, besides the REM nightmare and the REM anxiety dream. Therefore, it is suggested that a differentiation is made into different clinical phenomena: posttraumatic anxiety dreams/nightmares on the one hand, and posttraumatic nocturnal re-enactments on the other.

Related Phenomena

There are some sleep phenomena and disturbances which clinically bear a resemblance to the posttraumatic re-enactment. These are the night terror and the REM sleep behavioural disorder.

The night terror is a disorder of awakening. It may occur in children as part of their maturation process, and is then called pavor nocturnus. The phenomenon goes by the name of incubus when occurring in adults, where it is sooner associated with pathology. The classic picture of the night terror shows a sudden awakening, marked by a loud scream and followed by confusion, disorientation and automatic acting, sleep walking and motor activity lasting a few minutes up to half an hour. This arousal reaction in the night terror is, in fact, greater than in any other human response. Further, an intense autonomic reaction also accompanies the night terror. This consists of an enormously raised heart frequency, an increased respiratory amplitude and unresponsiveness to the environment. The person suffering from such a night terror usually wakes up early in the night, 60 or 90 minutes after he has fallen asleep. In sleep physiological terms, this awakening takes place during Non-REM sleep. In children, the pavor nocturnus is of longer duration. Also, children almost always appear to have no recollection of the dream contents. This is in contrast to most adults who are shown to have a fair to excellent recollection of the contents of their dream. These recollections are

usually short, but very lively. Moreover, the adults are capable of describing them in a very lucid manner.

There are many points of similarity between the incubus and the posttraumatic nocturnal re-enactments when these occur during Non-REM sleep phases. The only difference that exists between the two phenomena relates to the dream account. In the case of the incubus, the dream account seems considerably shorter.

The REM sleep behavioural disorder is another related phenomenon. This disorder involves the acting out of dreams through motor activity. This activity may sometimes be harmful to the person himself, or her or his partner. The clinical descriptions of these patients agrees with the various accounts of posttraumatic nocturnal re-enactments which I myself heard from patients and their partners.

It is striking that posttraumatic nocturnal re-enactments, excepting the dream content, show remarkably little resemblance to 'ordinary' nightmares and anxiety dreams, but seem the more related to such phenomena as the night terror and the REM sleep behavioural disorder.

Dream Accounts

Basically, the posttraumatic nocturnal re-enactment is defined through its dream content. The way in which the dream content refers to the traumatic experience determines whether or not we are concerned with such a re-enactment. And in its turn the dream, or the dream content, is largely defined by the sleep stage in which it occurs. In other words, the various sleep stages, which each show different mental activity, result in different sorts of dreams. Here a basic comparison is made between REM and Non-REM sleep stages. In Non-REM sleep, for instance, thought processes in a broad sense play a role. As a result, dreams occurring during Non-REM sleep are rather conceptual in nature, and less influenced by information from the previous day or by other recent information. Also, these dreams are less lively, less emotional and more controlled by willpower. In contrast, REM sleep involves much more the perceptual functions of the person asleep. Accordingly, the visual image of the dream during REM sleep is very lively, and has a rather compelling quality. It is in these two qualities that the characteristic peculiarity of REM sleep is to be found.

Returning to the posttraumatic nocturnal re-enactment, which takes place during Non-REM sleep, we notice that the mental activity accompanying it shows characteristics of both REM and Non-REM sleep. In order to explain this, it is useful to take into account again the phenomenon of night terror, which showed similarities with the posttraumatic re-enactment. Now, the night terror is thought to originate in a desynchronised activation of autonomic and motor systems. And, likewise, the same kind of desynchronisation appears to take place in the REM sleep behaviour disorder, which also bore some resemblance to the posttraumatic re-enactment. Analogously, it is now suggested for the posttraumatic nocturnal re-enactment that it is the result of desynchronised activation of different cerebral functions. This, in turn, would imply a more biological and behavioural origin of the phenomenon. Circadian rhythms might play a role in the process.

Clinical Consequences

We have now learned to distinguish the posttraumatic re-enactment and the posttraumatic nightmare, and in clinical practice the two phenomena can be differentiated.

A good anamnesis, if possible supplemented with a good hetero anamnesis, may already clarify a good deal. Besides, patients hardly ever complain of the 'ordinary' nightmare as such, whereas people suffering from re-enactments do complain. These patients then usually refer to their distressing dreams as 'nightmares'. Also, a fear of going to sleep at night would characterise patients suffering from re-enactments as opposed to patients beset by posttraumatic nightmares. Further, the account of the dream content itself differentiates between re-enactments and nightmares. But the best and clearest means to differentiate is, of course, polysomnographical examination.

After you have gone through a traumatic experience it is nowadays thought to be quite normal if you experience posttraumatic nightmares or re-enactments for the first weeks or months afterwards. The re-enactment of the trauma in this manner is seen as an expression of coping. But if these nightmares and re-enactments persist, it is reckoned the experience is coped with incompletely. This psychodynamic explanation may, however, not always be adequate. Reliving the psychotraumatic experiences in psychotherapy does not always work. The difference that exists between the origin and nature of the two phenomena could explain why.

The working through of symbolic anxiety dreams and nightmares is aimed at the integration of the traumatic experiences into present life. For re-enactments the pathogenesis seems to be of a more biological nature. Thus, psychotherapy should rather aim at mastering the re-enactments. In these cases, a directive kind of therapy might be the most powerful tool.

As for drugs, applying the same distinction between nightmares and re-enactments could specify the therapeutic effect they have. For instance, several drugs clearly decrease the amount of REM sleep and so have an effect on the re-experiencing taking place during REM sleep. But there seem to be less successful effects as well; doubt has, for example, arisen as to the long-term effects. The matter is, in any case, worth investigating further.

Further Reading

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