

LETTERS TO THE EDITOR

Long-term effects of treatment for chronic nightmares: is imagery rehearsal therapy robust in the COVID-19 pandemic?

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Nightmare frequency increases with exposure to stress. In her May 2020 article, “Spontaneous reporting of onset of disturbing dreams and nightmares related to early life traumatic experiences during the COVID-19 pandemic by patients with posttraumatic stress disorder in remission,” Gupta¹ found that 80% of patients reported nightmares linked to traumatic memories and not coronavirus disease 2019 (COVID-19) during spontaneous phone calls. Using standardized assessments to rule out bias, we investigated whether COVID-19 increased the prevalence of bad dreams in patients with chronic nightmares in remission.

In January–February 2020, we assessed the long-term effects of Imagery Rehearsal Therapy (IRT).² Just before the French lockdown (17th March), 29 of 48 patients completed 4-year follow-up questionnaires. To measure the effect of lockdown on nightmares and estimate IRT robustness, 23 of these patients completed these questionnaires² again at the end of lockdown (May). According to dream methodology recommendations,³ 2 patients were excluded having changed their antidepressant dosages and 1 because a traumatic event unrelated to COVID-19 occurred during lockdown. Our observations of 20 patients (3 men; average age, 39.5 years) with chronic nightmares 4 years post-IRT, with Wilcoxon matched-pairs tests, were presented thereafter.

Before IRT, the mean nightmare frequency per month was 28.8 (SD = 20). After IRT, it remained stable: 8.9 (SD = 8.9) post-IRT, 6.25 (SD = 10.6) at the 4-year follow-up. We confirm Gupta’s results¹ that the lockdown period increased nightmare frequency: 19.35 (SD = 32) (Nightmare Frequency Questionnaire: $t = 22.0$, $P = .003$); 13/20 (65%) reported increased nightmare frequency and 7/20 (35%) reported no lockdown effect. Only two reported more nightmares during lockdown than pre-IRT (without these two non-responders, nightmare frequency during lockdown was 9.5, SD = 10). The lockdown also deteriorated sleep (Pittsburgh Sleep Quality Index: $t = 2.46$, $P < .05$). A significant reduction in PTSD symptoms during IRT continued over 4 years (Posttraumatic Stress Disorder Checklist Scale, $t = 20.5$, $P = .008$). No lockdown effect was observed for other traumatic symptoms, generalized self-efficacy, or depression/anxiety.

During lockdown, nightmare content was variable: 85% featured worries, 75% conflict, 60% helplessness, 40% assault or failure, 20% illness, 10% lockdown, and 5% COVID-19. This

result confirms that nightmares are not “exact replay” dreams representing actual events. Only 30% dreamed about their original trauma. During such crises, increased nightmare frequency could be interpreted not only as reactivation of traumatic memories but also as an increased need for emotional regulation.⁴

For treatment responders ($n = 18$), 4 years after IRT, nightmare frequency was 9 times lower than pretreatment, and the COVID-19 pandemic tripled this frequency, which nevertheless remained 3 times lower than pre-IRT. IRT therefore seems robust to the effects of stress (no renewal effect) and time (no spontaneous recovery).⁵

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