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**Case Report**

# The Terrors of the Night: Creative Psychotherapeutic Approach in a Case of a Child with Parasomnia

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**Abstract**

Night terrors are phenomena that emerge in the phase of deep sleep in children and that are extremely disturbing for the parents. While research suggests that they tend to resolve by middle childhood, in children where these persist and cause dysfunction, behavioral interventions have proved to be useful. The paper presents the case report of an 8- year- old boy, who presented with night terrors and a decline in academic performance. In therapy along with using behavioral techniques and parent management strategies, creative modalities including art-work and play were employed. The child though vocal could not describe vocally the nighttime events or his understanding of possible stresses. With the use of projective techniques in assessment and semi- structured techniques in therapy, several difficult and possibly traumatic life events were understood and resolved with the child.

**Key words:** Night terrors, child, art, play, trauma, psychotherapy

## Introduction:

Parasomnias are a group of ‘‘undesirable physical events or experiences that occur during entry into sleep, within sleep, or during arousals from sleep’’[1]. Arousal disorders are a subset of parasomnias that arise in Non - Rapid Eye Movement (NREM) sleep in the first

third of the night. Amongst these, night terrors are in which the child awakens from deep delta sleep and exhibits wakeful behavior characterized by fright, motor agitation, vocalizations and autonomic symptoms. During the episode the child is inaccessible and unresponsive to the environment and afterward has little or no recall of the event. Night terrors have the greatest incidence in preschool children and have been found to largely disappear in adolescence [2], though in a few cases they may persist into adulthood [3]. The night terrors also are cause for great parental distress [4, 5].

Early research in night terrors discussed the role of psychic material in triggering these episodes. Psychological conflict was hypothesized to precede the intense panic and screaming that characterizes night terrors. While there is marked amnesia for the episodes in a majority of cases, these hypotheses have arisen from those persons with some recall [6]. Fisher et al found through interviews experiences of being crushed, trapped, abandoned, fear, falling and dying during the night arousal in adult subjects who had vague or good recall. Gau and Soong [7] cite study of Kales et al, which used Minnesota Multiphasic Personality Inventory (MMPI) and the Symptom Checklist (SCL – 90) to establish an association between anxious and depressive disorders and sleep terrors. In Gau and Soong's own study which employed the Junior Eysenck Personality Inventory (JEPI) and the Kiddie – SADS – E (Schedule for Affective Disorders and Schizophrenia for children – Epidemiology Version), children with sleep terrors scored higher on neuroticism and had more psychiatric diagnoses than the control group. Adolescents' sleep terrors have been associated with histories of enuresis [7], which has in turn been consistently related to emotional and behavior childhood problems [8].

Recent research has etiologically understood night terrors as manifestations of immaturity of the central nervous system rather than psychical disturbances [2]. In treatment of arousal disorder, and specifically night terrors behavioral management has been

consistently advocated, along with education of the parents [2,9]. Attempts to explore the internal processes in sleep disorders through creative and expressive techniques are largely absent. However these modalities in psychotherapy have been found to be beneficial with children who have undergone trauma and exhibit somatic symptoms and emotional problems [10, 11]. Expressive therapies in the Indian context have been studied through case reports of trauma [12,13] and emotional disturbances [14].

In the case report presented below, under the supervision of the second author, creative modalities have been used in therapy to work with night terrors. The child's condition was a cause of great distress to the family members and led to greater day-time sleepiness and poorer concentration of the child.

**Case Master A**

A, an 8 year old male child, studying in class III, from upper middle socio- economic status, reported with his parents to the hospital with a five year history of sleep 'episodes'.

No family psychiatric history was found. A is the older of two siblings. His intellectual functioning was clinically average. He enjoyed spending his time playing outdoors and indoors and disliked engaging in academics once he returned home from school. Temperamentally, A was a slow- to- warm child and was friendly with peers at school as well as to his cousins.

The night – time 'episodes' that he presented which occurred 45 minutes to one hour after the child had fallen asleep and lasted for 7- 10 minutes. The episodes were characterized by the child awakening and searching for something. He gestured as though frightened and ran around the house. He spoke in an unusual manner and the parents could not decipher the language he was speaking in. During this time he did not comprehend or respond to the voices of others. After about 10 minutes, the child would

be forcibly taken to the toilet by his mother, where he would urinate and then return to his bed and fall asleep. The child had no recollection of this episode the next morning. These episodes would occur once or twice a week. The parents had video – recorded an episode which was seen by the treating team. Neurological evaluation, including electro – encephalogram (EEG) and magnetic resonance imaging (MRI) was found to be normal. He had a history of adenoid gland inflammation, speech delay and recent academic decline. His parents reported that he did not like going to school or completing his school–work in last 2 years. He was also particularly sensitive to loud sounds and suffered from frequent headaches.

He was referred to the department of child and adolescent psychiatry for diagnosis and management of his sleep episodes.

**Assessment**

The Children's Apperception Test (CAT) was administered to understand interpersonal conflicts with parents, sibling and peers [15]. The Draw a Person Test (DAP) was administered to tap into the child's self-concept, fears and anxieties [16]. The Raven's Controlled Projection Test (RCPT) was administered for the child to express about his relationships with parents, the perceived relationship between parents and conflicts in other interpersonal domains [17]. Projective tests were chosen so as to tap into the child's unconscious processes and elicit information about anxieties, which the child may not be consciously aware of.

Difficulties with sleep emerged as an important theme in the CAT stories. On the RCPT, he expressed that dreams were frightening and reported that the boy (protagonist) dreams that the 'snake is eating all of them'. Underlying aggression towards the mother figure and towards younger/ smaller figures was elicited. A father figure remained largely absent from the stories. On the DAP the child saw female figures as being weaker and

less happy. Conflict with his sister emerged when he described a boy without any siblings.

Parents were interviewed for possible stressors in the family context that may contribute to the child's symptoms. The parents reported that on one occasion the episode occurred shortly after the child had watched a spider- man cartoon on television. They were educated about avoiding violent material even in cartoons with children and for A, especially before bed - time.

**Psychotherapy sessions**

*Initial phase (Session 1 to 5)*

In each session an hour was spent with the child and about half an hour was spent with the parents trying to detangle possible stresses or subliminal cues in the environment each week. The initial sessions focused on increasing the rapport and comfort of the child, and creating a safe space for him in therapy.

With the parents, discussions to ensure better sleep quality were initiated. The use of calming music, avoidance of loud, arousing stimuli and the provision of a safe sleeping space were advised. The mother reported that she would often put the child to sleep and wouldn't stay with him as he fell asleep because she needed to look after her younger child. She was asked to stay with him until he fell asleep and a little beyond, and physical touch was encouraged. Since the episodes occurred about 45 minutes after the child fell asleep the mother was asked to wake him up 30 minutes after he slept and keep him awake for about 15 minutes. This however, was done few times and with reluctance from the family as the child did not like been woken up from sleep and would find it difficult to stay awake. Parenting patterns and means to reduce criticality, comparison and physical punishments were discussed. The parents were asked to debrief the child about the events of the day so that he was not preoccupied with them when he slept.

Relaxation using imagery and breathing exercises was practiced with the child to help address anxiety and arousal symptoms and he was encouraged to practice these before bedtime.

*Middle Phase (Sessions 6 – 16)*

Over the course of therapy, the frequency of his episodes fluctuated, at times occurring weekly, but it never returned to its original frequency.

Art - work was introduced with the child and various themes in art were explored including family, holiday, school, and subsequently more abstract ideas of safety and fear. During this time the child recalled having a dream of a dinosaur attacking him and he drew this in the session. The dream was discussed and reframed for it to be less perturbing. The theme of fire emerged repeatedly in the child's drawings as well as in his accounts of his imagination. He would report/ draw that he was running away from a large fire and would describe falling buildings and people running to save them. He also began to dream about fire and would be very disturbed by these dreams. The therapist explored past events that could have fueled this preoccupation with this theme but the child said that he was not afraid of fire and would often play with matches and candles at home. He could not recall any adverse event related to fire. The parents too could not provide any event in the child's life associated with trauma or fear of fire. Art – work involving fire was discussed with the child and he would tell detailed stories about firemen who would rescue the people from the burning houses. Thus the theme was reframed into its less frightening and more empowered connotations. Over sessions, fire related imagery that he reported spontaneously decreased.

In his drawings about his family and in the initial assessments, conflict and aggressive impulses in relation to his younger sister emerged. She was three – years – old and about five years younger to the child. He reported that he loved her but preferred not to play

with her, as he was a ‘big boy’. The mother reported some instances wherein he would be inattentive and uncaring towards her.

Over the course of the sessions the parents supplied several instances, which could have been of importance to the child’s mind. They reported that he was two – years – old when he was circumcised. He became very anxious during the procedure and cried incessantly afterwards. The mother also felt that the procedure could not be done properly because the child was extremely disturbed. The episodes seem to have started soon after this event. This experience may be of significant traumatic potential in the child’s internal world. Circumcision trauma has been understood to long lasting sequelae including features of trauma, feelings being mutilated and violated, and anger [18].

In therapy the dilemma of working towards resolution of this trauma arose. Is it ethical to probe about an event that may have been traumatic but that the child may not remember? While for adults bringing repressed material is to consciousness may be imperative in certain therapeutic approaches, for children whether this was feasible or useful was an important question in the therapists mind. In play and art work, direct referrals to this event did not emerge. Images that may be understood as phallic symbols – the dinosaur, missing finger in drawings, did emerge but these were discussed through stories and art without offering any other interpretation.

Another significant event that the parents discussed was that when the child was three – years – old his father had travelled to Mumbai for work. It was at this time that Mumbai city was attacked by terrorists and was under siege. The mother being worried for her husband’s safety had been following the news on the television and images of gunfire and bombings were continuously being watched for three days. Finally the child’s fear of fire seemed to make sense and it seemed as though he had suppressed this memory. This event was discussed with the child but he approached the conversation in a manner

devoid of emotions. He remembered vaguely that such an event had taken place and that his mother was scared, but could not attribute any of his own emotions to it.

At this point it appeared that significant events were taken place around the ages of two and three for this child – the circumcision and the terror attacks. At the age of five, his sibling was born. It was hypothesized that these events had left their imprints on the child's mind and caused him intrapsychic anxiety that he possibly could not verbalize. In this formulation the child's speech delay appeared to be important as during the years in which he experienced these events, he perhaps has minimal verbal expression and thus was not able to express in words his complex emotions even in therapy.

He was introduced to the play - room to help better resolve the conflicts that these events had potentially created. A non- directive approach to play therapy was adopted. The child hesitantly explored the play - room at first and soon began to enjoy himself. He liked to play in the sand pit and would spend several minutes filling sand in the buckets. He made clay sculptures and looked at the therapist for approval when he was finished. In dealing with dolls and human figurines he was aggressive and in his gestures, elders would often discipline the children harshly. However, he rarely spoke out loud. He would have elaborate enactments with dolls but would not say anything audible. The last two times that the child was in the play room, he put up a puppet show, as though to engage the therapist in his play. At these times he acted the roles of the puppets in a hesitant but audible voice. The story revolved around a boy who was loved and happy at home and at school. A total of 6 sessions were done in the play room. The child would report that the play - room was his favorite activity and it made him very happy.

*Termination Phase (Sessions 17 – 18)*

Two sessions were planned for termination. The child was given free reign to choose what he wanted to do and chose to draw and talk to the therapist.

In the process of therapy the child was able to verbalize his feelings better and the frequency of the 'episodes' decreased to once in a month. He said that he was happier at school and at home and felt less scared now, although he did not know what he was sacred of in the first place. He was also keener to complete his school work. Parents also reported better adjustment with peers at school and with his sister at home.

The parents decided that they would continue to practice the skills discussed at home and would consult again if required.

In the last session, the mother revealed to the therapy supervisor that she had suffered from dissociative possession 'attacks' and that her son had witnessed these. These 'attacks' had occurred at night and it was due to this that she had initially begun to sleep separately and away from the children. This was important information that could not be further understood as the family stopped coming for therapy.

On follow up after 1 year, it was found that the gains of the psychotherapy were maintained, though an increase in the frequency of episodes to fortnightly occurrences was observed around the time of the child's examinations at school (for a period of one month). At 12 month follow up the family reported that the episodes occurred once in 50 days approximately and that the child's performance at school had improved with lesser avoidance of school - work and greater enthusiasm with regard to academics.

**Discussion**

This case description is based on the assumption that psychic trauma has an etiological role in sleep terrors, a hypothesis that has not been discussed at length since the 1980s [3,6,19]. In a study by Smedje et al 2000, among 635 children, 36% of those with sleep problems; also had behavior problems and 15% with behavior problems suffered from global sleep problems. Emotional problems were associated with global sleep problems, prolonged sleep latency and night terrors. The authors emphasized the relationship

between psychological trauma and night terrors [20].Psychological trauma was found to dictate the content of sleepwalking / night terror episodes in another study with adults [21]. Several authors have theorized links between sleep regulation and emotional and behavioral regulation [22], but literature is scarce on the psychological basis of night terrors in children. In the present case, in the process of creative exploration, there emerged several potentially traumatic events of which the circumcision trauma was perhaps the most potent of all. In a study of 12 boys who were circumcised in late childhood, the circumcision was seen as an attack and a mutilation of the body. It was associated with aggression, nightmares, post- traumatic stress disorder and impaired functioning [23]. The age at which these experiences were lived is also of consequence. Literature on trauma before the attainment of verbal skills shows that pre-verbal trauma has behavioral, emotional and physiological manifestations [24]. In cases of mildly anxious trauma, reenactments in therapy may be beneficial [25]. In these cases, the use of expressive means to explore these experiences may be useful as demonstrated in the case above. Working through these traumatic events directly and indirectly led to decrease in symptoms and better psychosocial adjustment. The study however, is limited in its evaluation of improvement, which is based solely on the report of the child and his parents and no objective measures were applied. The case presents opportunities for exploration of the psychological substrates of parasomnias in children and for psychotherapy research in this area.

**Conflict of interest:** None declared.

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