

Dissociation, Somatization and Suppressed Anger in Craniomandibular Disorders and Bruxing Behavior subjects with current history of nightmares.

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Abstract:

Introduction: Nightmares constitute moderate to severe sleep disorders that may be reported by craniomandibular disorders and bruxing behavior subjects and may indicate psychopathology. Little is known about these complex interrelationships. **Goals:** Evaluate scores in dissociation, somatization and suppressed anger in Craniomandibular Disorders and Bruxing Behavior subjects who reported nightmares at the time of examination. **Methods:** Medical records of Craniomandibular Disorders and Bruxing Behavior subjects with and without history of current nightmares previously referred to an Orofacial Pain Unit were consecutively retrieved from a database and retrospectively assessed. Clinical examination, history of the chief complaint, self-report, a set of questionnaires, palpation of muscles and joints, biomechanical tests to diagnose type of internal derangement of the temporomandibular joint, the Bernstein and Putnan questionnaire for dissociation, the Rief and Hiller questionnaire for somatization and a self-reported questionnaire to evaluate anger taken inward were used to gather data. A self-reported instrument was used to obtain information about presence, types and affects in nightmares. Forty-five individuals with craniomandibular disorders, bruxing behavior and a history of nightmares and a similar sample but without nightmares were evaluated and compared regarding dissociation, somatization and suppressed anger scores. Mann Whitney statistics was used to analyze data.

Outcome: Mean scores in dissociation was about 27,3 (SD=15,8, range=10-63) in the Craniomandibular Disorders, Bruxing Behavior and Nightmare subgroup and 13,8 (SD=5,6, range=8-28) in the Craniomandibular Disorders, Bruxing Behavior and no history of nightmares (Mann-Whitney statistics $p<0,0002$), an extremely statistically significant difference. Mean scores in somatization was about 12,4 (SD=5,0, range=5-23) in the Craniomandibular Disorder + Bruxing Behavior + History of Nightmare and about 9,3 (SD=3,7 range 5-17) in the Craniomandibular Disorders + Bruxing Behavior and no nightmare history. Mann-Whitney statistics ($p<0,01$), a statistically significant difference. Mean scores in suppressed anger was about 187,4 (SD=45,7, range=106-290) in the Craniomandibular Disorders and Bruxing Behavior + nightmare history subgroup and 135,9 (SD=36,4 range=53-211) in the Craniomandibular Disorders + Bruxing Behavior no history of nightmares subgroup. Because Mann-Whitney statistics ($p<0,0001$), we can state that the difference was statistically extremely significant.

Conclusion: Subjects in the Craniomandibular Disorders and bruxing behavior subgroup demonstrated higher scores in dissociation, somatization and suppressed anger, providing additional data on the general concept that such subgroup is psychologically and psychiatrically more complex.

Keywords: Craniomandibular disorders. Bruxism. Dissociation. Somatization. Suppressed Anger. Nightmares.

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I. Introduction

Craniomandibular Disorders (CMDs) constitute collective terms used in Medicine, Dentistry and Physical Therapy to describe a set of signs and symptoms occurring in a restricted anatomic region usually involving pain and dysfunction in the masticatory muscles, temporomandibular joints (TMJs) and adjacent anatomic structures, usually of musculoskeletal origin^[1]. Well defined signs and symptoms including a

complain of pain usually in the pre-auricular area, impaired jaw movements, joint noises, tenderness to palpation and headache, constitute characteristic signs and symptoms of CMDs^[2].

Bruxing Behavior (BB) is a very complex oral jaw behavior described as “the habit of grinding, clenching, bracing or gnashing the teeth with no functional purposes usually observed at daytime, nighttime or both. The behavior has also been defined as a neurological and motor disorder thought to occur in different stage of sleep^[3] The definition of BB is changing constantly as new clinical and neurophysiological studies indicate the presence of sleep bruxism in more complex neurophysiological disorders.. For instance, BB has been observed in association with REM sleep behavior disorder or RBD^[4]. BB is not only a psychological and/or psychiatric disturbance, but presents enormous clinical importance for the practitioner as the behavior is associated with a number of clinical symptoms or painful sites in the face, head, TMJs, oral structures and cervical region.

Dissociation is a psychiatric terms with the connotation of a disruption or pathological alteration of normal integration internal and external experience, consciousness, memory or perception of the environment characterized by the compartmentalization of experience in which, elements of some experiences are not normally integrated by the components of the mind, rather they are stored in isolated fragments^[6]. The importance of dissociation is that this disorder is closely related to somatization, a disorder commonly observed in CMDs individuals.

Somatization is a psychiatric disorder wherein mental states and experiences, more specifically those related with unbearable and non recognized psychic conflicts are transformed and expressed as bodily symptoms and usually implies the use of powerful defense mechanisms^[7] and their expression in different organs of the body including the face, the TMJs and the mouth. Somatization patients known as “somatizers” are those characterized by some psychological and unconscious psychic conflicts and their expression in many body organs and systems and by the persistent pursuit of medical advice and understanding of their disorders and numerous complaints.

The study of suppressed anger and hostility is of paramount importance as it is closely related with somatization, dissociation and depression. There is a close association between cynicism as a stronger predictor of sleep quality. Furthermore, individuals scoring high in hostility demonstrate heightened reactivity to stressors that may activate some neurophysiological mechanisms to trigger signs and symptoms of somatization and nightmares. Hostility is not only associated with BB and CMDs but also with some systemic diseases including cardiovascular disease. In Mikami’s^[8] literature review, he reported that bruxers are stressed individuals who use their teeth to vent out aggression. Furthermore, blocked drives and desires may encourage the use of the oral tissues including the tongue, teeth, cheek and lips to release suppressed aggression. Life dilemmas and personal conflicts make bruxers more anxious, tense and enraged with a tendency to strangulate their aggression and take their frustrations inward^[8] which make bruxers more vulnerable to develop depressive disorders. Anger is a complex psychological phenomena and also a negative and unpleasant experience with both negative and positive consequences which may be classified as mild, moderate or severe and/or as anger taken outward and anger taken inward. Suppressed anger refers to the inhibition of anger feelings and may be observed in the normal population, in individuals with high levels of somatization and in those with chronic pain^[9]. Anger is a powerful affect implicit in many of the measures of hostility, sociopathy and mistrust. Further, anger, fear and sadness are some negative emotions of paramount importance in chronic pain patients^[9]. Suppressed hostility or anger is of paramount importance in the field of somatization. Abbas and colleagues^[10] report that suppressed anger is the most important affect transforming conflicts into symptoms in different organs and systems in many individuals or “somatizers”.

Nightmares are probably the most prevalent forms of sleep disturbance. Not only nightmares have a symbolic meaning, but also they are the result of more or less severe psychopathology. For the sake of clearness, in this study we define nightmare as a long frightening dream that may or may not awaken the sleeper. Because not all sleepers awake as a result of dream content, the definition of “a disturbing frightening and unpleasant dream in which a range of emotions including fear, disgust, anger, sadness are displayed”, is currently preferred^[11]. Physical aggression, interpersonal conflicts, fear, failure and misfortunes are common themes or situations depicted in nightmares and bad dreams^[12]. Furthermore, a great variety of themes including being chased, being the victim of physical injury and threat against personal integrity, attack and witnessing violence, are other common themes reported in nightmares and bad dreams^[12] Nightmares and bad dreams are directly associated with bad sleep, decreased daytime performance, posttraumatic stress disorders and psychiatric illness^[13], probably depression, somatization and dissociation among others. Because there is a paucity of studies relating nightmares with dissociation, somatization and suppressed anger in CMDs and BB individuals, this investigation was designed to:

1. Test the hypothesis that CMDs and BB subjects reporting nightmares demonstrate higher scores in dissociation;

2.If dissociation is part of the psychological and/or psychiatric make up of some subgroups of CMDs and BB subjects, they are more likely to demonstrate higher scores in somatization and suppressed anger.

II. Methods

Patients or subjects referred consecutively to an Unit specialized in the diagnosis and treatment of CMDs, BB and Orofacial Pain (OFP) at UNIRG University School of Dentistry, are usually evaluated using a comprehensive and standardized clinical procedure described as follows: Taking the history of the chief complaint, palpation of the TMJs and major masticatory muscles, use of biomechanical tests to determine and diagnose the type of internal derangement of the TMJs, use of questionnaires, clinical examination and self-report to assess presence and severity of BB, another questionnaire to evaluate presence and type of headache. Finally, psychological tests including the Bernstein and Putnam instrument to evaluate dissociation and the Rief and Hiller self-reported questionnaire to gather information about somatization, the Taylor Manifest Anxiety Scale to evaluate anxiety and the Cook and Medley instrument to assess hostility are also routinely used. Two other instruments (The INAA 100 and the Anger Inward instrument) were also used to gather information about nightmares and anger taken inward, respectively in CMDs and BB subjects. Once examination, palpation and biomechanical tests were completed and subjects respond to various questionnaires, the clinical records are stored in a database for future use when the researchers wish to explore a specific variable of interest, for instance, depression and hostility in subjects who reported nightmares.

Recently, we consecutively retrieved 45 medical and dental records from CMDs and BB subjects who had reported history of nightmares and 45 medical and dental records of an equal number of CMDs and BB subjects who did not report nightmares during sleep. Such medical records were evaluated regarding presence or absence of nightmares, scores in dissociation, somatization and anger taken inward.

Criteria for the presence of CMDs: A complain of pain in the masticatory structures, presence of joint noises in the TMJs based on self-report and gentle digital palpation, difficulty to perform normal jaw movements, tenderness to palpation of joint and muscles, and headache of musculoskeletal origin, for instance, head pain referred from the masseter and or from the TMJs.

Criteria for nightmares: The meaning and definition of nightmares was explained to the patient. Then, he or she was asked about the presence or absence of nightmares. Once he or she responded (yes or no) to this question, he or she was invited to respond to a questionnaire about nightmares or dreams. A yes or No response was sufficient to accept that he or she was or no a nightmare sufferer. The questionnaire was responded in order to gather information about types of dreams or nightmares and major affects present during dreams reported by the subject.

Exclusion criteria in the study: Subjects and controls presenting with severe psychiatric or psychological disorders, cognitive difficulties to respond properly to questionnaires, presence of neuromuscular disorders included but not restricted to Parkinson Disease, speech and motor disorders and those subjects that had been examined and that by some reason information was incomplete and could not be neither stored in the database nor used for any epidemiological or clinical study. Such clinical records were excluded from the investigation.

III. Measures

The Bernstein and Putnam^[14] self-reported questionnaire is an instrument that was developed by those researchers to gather information about dissociation. The 28 item self-reported questionnaire exposes the reader to a list of 28 situations of the everyday life in which the frequency of occurrence is graded from 0% (indicating never) to 100% indicating always. The Rief and Hiller^[15] self-reported questionnaires is a list of items developed to gather information about complaints and symptoms in different parts of the body. The subject responds to the questionnaire with the words never, rarely, occasionally, frequently and always to any of the questions of the instrument. Thirty two questions from the questionnaires were used in the current investigation to assess somatization in CMDs and BB individuals. The Suppressed Anger questionnaire is an instrument developed by the first author of this study (OFM), to gather information about anger taken inward when relating to other people or situations. The instrument exposes the subject to 29 questions related to anger or rage taken inward to which the reader or subjects responds in a scale of 0 to 10 in order to determine the frequency that the event occurs. The INAA-100 is a 100-item instrument developed by the author in order to gather information about frequency and types of nightmares and most common affects displayed by the dreamer.

IV. Statistical Analysis

Mann-Whitney nonparametric statistics was used to analyze data in the current study.

V. Outcome

Mean age in the CMDs and BB subgroup with nightmares was about 31,4 (SD=10,7, range=14-61) and 35,7 (SD=13,9, range=15-56) in the CMDs and BB subgroup without nightmares. Because Mann-Whitney statistics yielded a p-value=0,14, we can state that there was no significant difference when age was compared in these two subgroups. See Table 1 for further details.

Mean in dissociation in the CMDs + BB subgroup reporting nightmares was about 27,3 (SD=15,8, range=10-63) as compared to 13,8 (SD=5,6, range=8-28) in the CMDs + BB no nightmares subgroup. Because Mann-Whitney statistics ($p < 0,0002$), we can state that subjects in the CMDs + BB + nightmares demonstrated higher scores in dissociation as compared to the CMDs + BB no nightmares subgroup and the difference was extremely significant. See Table 2 for additional details.

Mean in somatization was about 12,4 (SD=5,0, range=5-23) in the CMDs + BB reporting nightmares as compared to 9,3 (SD=3,7, range 5-17) in the CMDs + BB no nightmare history (Mann-Whitney statistics $p < 0,01$), a statistically significant difference. See Table 2 for additional details.

Mean in suppressed anger was about 187,4 (SD=45,7, range=106-290) in the CMDs + BB + nightmare history as compared to 135,9 (SD=36, range=53-211) in the CMDs + BB no nightmare history. Because Mann-Whitney statistics ($p < 0,0001$), we can state that scores in suppressed anger were higher in the CMDs + BB + nightmare history and that the difference was statistically very significant. See Table 2 for further details.

VI. Discussion

Higher scores in **dissociation** were found in the subgroup reporting nightmares. Because this subgroup demonstrated higher scores in other disorders (somatization and suppressed anger), it seems apparent that CMDs + BB + **nightmare history** subjects constitute a psychologically and or psychiatrically more complicated subgroup in which dissociation, somatization, personal conflicts and life dilemmas predominate. Thus, not only this subgroup is more likely **inclined to dissociate to avoid traumatic and disturbing material during the day** but also dissociate at night in the form of nightmares. Dissociation in these individuals is very likely triggered by stressful and traumatic daytime events which are interpreted in the mind as **reminiscent of emotional, sexual and/or physical abuse** in childhood and/or adolescence and or as **“threatening events”**. Providing partial support to these assumptions, one investigation^[16] indicates that dissociative experiences during daytime in those previously exposed to traumatic events can also occur at night and may be represented in some parasomnias^[16].

In the current study we found higher scores in dissociation in those subjects demonstrating signs and symptoms of CMD, BB and current history of nightmares.. Thus, the outcome in this investigation is supported by one study^[16] indicating that subjects who reported nightmares had higher scores in dissociation. One investigation^[17] evaluated a subgroup of 30 patients with dissociative disorders. Researchers found a high prevalence of nightmare disorders. Further, subjects with dissociation and nightmare disorders had a higher rate of self mutilation behaviors, a history of suicide attempt and borderline personality disorders indicating that those subjects with dissociation and nightmares had a complex and very pathological personality. One investigation^[18] reported that some indices of sleeping problems including nightmares and insomnia, use of sleeping medication and daytime dysfunction due to sleeping problems were positively associated with dissociation.

Regarding the relationship between “stressful and threatening events” and dissociation, the previously exposed considerations and assumptions are strongly supported by one investigation^[12] asserting that physical aggression and interpersonal conflicts are the most frequently reported themes in bad dreams and nightmares. It is very likely that in CMDs and BB subjects reporting nightmares, at least some stressful events are interpreted as threatening to physical integrity or even to life. Such events are suppressed at daytime through powerful defense mechanisms, but emerge at night as different characters in bad dreams and nightmares. This assumption is reinforced by one investigation^[12] indicating that nightmare content is more strongly related to themes involving a direct threat to physical integrity. It is very likely that when external undesirable and unpleasant events trigger rage and aggression that reach a certain level but are suppressed and denied expression during the day, they may appear as rageful or aggressive characters in nightmares and bad dreams^[19].

Regarding the relationship between dissociation, parasomnias (nightmares) and emotional, physical or sexual abuse, one investigation^[20] in subjects with parasomnias and higher scores in dissociation reported higher scores in emotional, physical and sexual abuse^[20]. Hostility is not inborn but results from events in the child's life usually associated with the most significant objects (mother father, siblings) which are interpreted as excessively painful by the child^[21]. Such events usually physical, emotional or sexual, constitute the basis for

somatization and dissociation as etiological elements. There is a close relationship between dissociation, nightmares and severe physical, emotional and sexual trauma. Nightmares occur frequently in posttraumatic stress disorder following an intensely frightening or highly emotional experience^[13]. Traumatic experiences of various types are known to disrupt both daytime and nighttime experiences since trauma usually triggers daytime dissociation and sleep disturbances such as nightmares. Nightmares are positively associated with schyzotypic personality, dissociative disorders and childhood traumatic events^[18].

In the current investigation we found higher scores in dissociation and **somatization** in the subgroup with CMDs, BB and self-reported nightmares. Many studies have described a very close relationship between dissociation and somatization and CMDs individuals and even bruxers have been described as “somatizers or psychosomatics”^[8]. Supporting this point of view, Fisher’s^[6] studies indicate that the clinician must carefully examine the presence of signs and symptoms of somatization which are observed frequently in dissociative individuals including unusual pain tolerance, headaches and or difficulty to respond to pharmacological medication.

One investigation^[2] evaluated depression, somatization and anxiety in female patients presenting with CMDs. Even though researchers did not evaluate dissociation they found that CMDs subjects were characterized by higher scores in somatization and depression. Further support to findings reported in the current investigation comes from one study^[22] assessing depression and somatization in CMDs subjects. Even though researchers did not evaluate neither dissociation nor nightmares, they reported that CMDs patients may be characterized by a profile in which high level of disability, more severe pain and higher levels of somatization predominate. Finally, one research^[5] evaluated painful sites, depression and somatization in bruxers and CMDs subjects and reported higher scores in depression, somatization and painful sites in the experimental group as compared to the control one.

Higher scores in **suppressed anger** were found in the subgroup reporting nightmares and higher scores in dissociation. It may be that CMDs and bruxers subjects with dissociation, somatization and nightmare have developed powerful and protective defense mechanism by which intolerable affects and daytime stressful situations are denied or separated from conscious awareness. At least part of these traumatic experiences gain “momentum and expression” at night in bad dreams or nightmares. Congruent with these assumptions, one investigation^[23] on dissociative disorders indicate that dream and nightmare characters constitute projected parts of the dreamers’ self which have been denied full expression during the day^[23]. Furthermore, in the studies carried out by Mikami^[8], he described bruxers and CMDs individuals as those that use the teeth to release aggression. His review indicated that BB habit seems to be more severe when some life dilemmas that make bruxers anxious, tense and enraged, are not resolved. At least part of this tension, frustration and rage may be worked out or elaborated in nightmares and bad dreams. Further, that researcher^[8] believed that aggression that is not released during the day, frustration, anger that is suppressed and taken inward, and psychosomatic disorders, are characteristics of BB individuals. Nightmares are significantly more emotionally intense than bad dreams and both nightmares and bad dreams contain emotions like anger, sadness and frustration^[12].

It may be that intense anger and frustration which are suppressed or inhibited at daytime in CMDs and BB individuals, find expression in some characters represented in bad dreams and nightmares. Anger turned inward is more likely to be expressed at night in such individuals. In line with this point of view, one study^[4] indicates that a higher prevalence of sleep BB was found in subjects presenting with violent parasomnias during sleep as compared to individuals without violent parasomnias. It has been reported^[20] that undesired and disturbing traumatic experiences re-emerge in deep wave phase and sleep parasomnias can be accepted as a variant of dissociative process which disrupts sleep by organizing an arousal situation.

VII. Conclusion

Higher scores in dissociation, somatization and suppressed anger were found in subjects with CMDs, BB and self-reported nightmares. Thus, this investigation reinforce the general concept that CMDs and BB subjects are psychologically and psychiatrically more complex. Even though this was a retrospective cross-sectional study and has inherent limitations, the novelty of the investigation is that it opens an avenue of research in this field. For instance, other researchers may be attracted to investigate the mechanism and etiological factors of nightmares and/or amplify the psychological profile of CMDs and BB individuals. New studies are highly recommended using similar samples and psychological instruments to further validate the outcome of this investigation.

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Table 1: Social and Demographic data in 45 subjects with CMDs, BB and nightmare history and 45 subjects with CMDs, BB and no nightmares history.

	CMDs+ BB + NIGHTMARES	CMDs + BB NO NIGHTMARES
AGE		
Mean	31,4	35,7*
SD	10,4	13,9
Range	14—61	15---56
GENRE		
Females	44=97,8%	40=88,9%
Males	1= 2,2%	5= 11,1%
TOTALS	45=100%	45=100%

*Mann-Whitney statistics (p=0,14), a statistically non significant difference.

Table 2: Means, Standard Deviations and Ranges in Dissociation, somatization and suppressed anger in the subgroups with CMDs, BB and nightmares history (n=45) and in the group with CMDs, BB and no nightmares history (n=45).

SUBGROUPS	DISSOCIATION			SOMATIZATION			SUPPRESSED ANGER		
	Mean	SD	Range	Mean	SD	Range	Mean	SD	Range
WITH NIGHTMARES	27,3	15,8	10-63	12,4	5,0	5-23	187,4	45,7	106-290
WITH NO NIGHTMARES	13,8*	5,6	8-28	9,3**	3-7	5-17	135,9***	36,4	53-211

*Mann-Whitney statistics (p<0,0002)

**Mann-Whitney statistics (p<0,01)

***Mann-Whitney Statistics (p<0,0001)