Sleep Disorders and Hypnosis: To Cope or Cure?

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In a brief review of current thinking of the Sleep Disorders, the inadequacies of traditional aetiology are challenged. Furthermore, some therapies may be worse than the symptom. General agreement is that sleep disturbance is but a symptom of an underlying problem. However, the latter is very rarely addressed in traditional medicine, psychiatry or psychology. Modern techniques of Clinical Hypnosis provide an ideal method of identifying and eradicating the true cause-the subconscious mechanisms of survival. This mechanism involves hyperarousal that compels the patient to remain alert in order to deal with the perceived threat. The best opportunity to eliminate the symptom and avoid alternative symptoms in the most cost-effective manner is through the use of Analytical Clinical Hypnosis. This is short term, does not require expensive facilities or in-patient treatment. Medical Hypnoanalysis is offered as such a consistently successful method. This includes a discussion of the underlying subconscious survival mechanisms and the investigation and management of a patient's symptom. **(Sleep and Hypnosis 2002;4(1):39-46)**

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INTRODUCTION

Definition

Disturbances that affect the ability to fall asleep and/or stay asleep; that involve sleeping too much, or that result in abnormal behaviour associated with sleep (1,2).

Classification

A variety of classifications are still in use by various authors. However, in brief they may be:

- Primary: long-standing, with little apparent relationship to immediate or psychic events.
- Secondary: Due to acquired pain syn dromes, anxiety, drug or alcohol related or depression.

Alternatively, they may be classified as:

- Transient: lasting less than three weeks and often related to a recognised life event. These are described as emotional events, changes in environment, excessive alcohol or caffeine and jet lag.
- Cyclical: Described as occurring premen strually, in manic depression and anorexia nervosa
- Chronic Insomnia: This is by far the com monest and the most troublesome in terms of morbidity.
  Associated with chronic insomnia is a state of hyperarousal–awake or asleep.

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There are three patterns described:

i. Initial insomnia–difficulty in getting to sleep and associated with anxiety and restless legs syndrome.
ii. Difficulty maintaining sleep–often associated with nocturia, organic pain, asthma etc.
iii. Early Morning Waking (EMW)–most commonly associated with depressive disorders.

Effects

These are largely related to the deteriorating symptoms of anxiety-depression with increased anxiety, poor concentration, lowered mood, anger, and deteriorating memory skills. There may be somatic conversion with exhaustion, muscle pain and other symptoms.

Traditional Management

Since it is the commonest and most troublesome, discussion will centre on "Chronic Insomnia".

Management has very largely been centred around reasonable

advice as to exercise, relaxation, avoidance of caffeine and alcohol, avoiding sleep during the afternoon and so on. While this is all sound advice, it is of very little positive benefit to the vast majority of patients.

Non-prescriptive hypnotics.

These are generally herbal preparations and the older classes of antihistamines. Similarly unsatisfactory, they may also carry the risk of side effects such as daytime drowsiness.

Prescription Hypnotics.

A wide variety of short and long acting benzodiazepine and allied drugs are available. The major risks particularly in the long acting drugs are rapid dependency and addiction as well as psychomotor performance. It should be noted that despite the claim by one or two pharmaceutical houses that their product had never been shown to produce dependency, this has not been the clinical experience. Every psychoactive drug has the potential for addiction–a condition that compounds the original symptom!

Cognitive Behavioural Therapy, Chronotherapy and Light therapy.

These have proved useful in some cases yet time consuming and usually involve at least the temporary use of hypnotics.

Comments

While a whole host of "causes" or aggravating factors are blandly offered, none of them deal with the true underlying causes and therefore rarely effect a cure. The symptom may be modified and the patient may cope; yet they are vulnerable to relapse, to emotional disorders and addiction.

Every "trigger" mentioned above is merely the signal for the subconscious mind to act on the patient's behalf. Noteworthy is the fact that most of these triggers are mere labels applied to a patient, for example, depression.

Depression itself is a symptom of underlying subconscious mechanisms! These are very rarely recognised by the uninformed clinician or lay public as they are by their very nature masked or hidden from conscious thought processes (3).

The vast majority of these factors causing and aggravating sleep disorder are functions of subconscious survival, which takes place without conscious awareness!

Traditional treatment is unsatisfactory for many patients:

- There are the dangers of tolerance and addiction to drugs.
- Cost-effectiveness is unsatisfactory in many cases.
- There is the danger of collusion with the patient's subconscious in maintaining emotional dependency and transference.
- There is the paradoxical danger of entering into a survival battle with the subconscious–which becomes apparent when subconscious function is discussed.

THE FUNCTION OF THE SUBCONSCIOUS MIND

In a word, SURVIVAL!

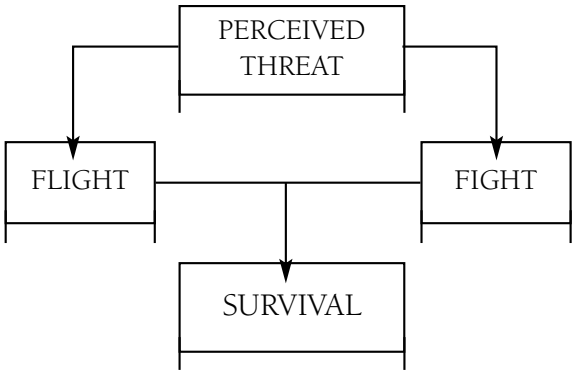
The symptom is based on the individual's learned subconscious response to a prior event–a habitual, conditioned and subconsciously fulfilled survival response (4).

The Subconscious Mind functions 24 hours a day, in wakefulness, sleep, coma and anaesthesia.

Its primitive logic is extremely limited–to the assessment of the individual's survival needs in any given situation, at any given time. It is constantly assessing every single event in life as one of two things: "Does this support life?"…or: "Does this potentially lead to death?" If the conclusion is the latter, *the subconscious is compelled to engineer survival through the hypothalamic-limbic-endocrine-sympathetic nervous system cascade. This is the described state of hyperarousal–it is designed to keep one alive. It follows therefore that the symptom of insomnia is the "Proof of Life"* (4-6)

In the presence of a perceived threat to survival and even if this response is illogical, it must and will take place. Patients presenting for assistance with insomnia consciously want to sleep yet their subconscious survival needs take priority. They are left with a feeling of helplessness, even hopelessness as these mechanisms take control.

A simple flow chart makes this clear (7,8):



However, should neither Flight nor Fight achieve the goal, the only other option for Subconscious Mind to remove the threat is to enter the Giving up–Given up mode. In essence, there is a subconscious acceptance of Death before it has actually occurred. This "death" may be at any level-be that sexual, territorial, physical, self-esteem or spiritual. It is this faulty subconscious belief that "I am as good as dead" or that "life is no longer worth living" that is the precursor to depression. (4)

A good metaphor is that of a mouse trapped between the paws of a hunting cat. The mouse, having exhausted itself in a failed flight and not being able to defend itself by fighting, simply becomes immobilised. It withdraws from the terror of the inevitable, which is death. Subconsciously, it is better to be dead and not feel than to continue to experience the horror of the threat. This is the ultimate defence – to shut out the future! This results in hypersomnia – to the subconscious it is better to be sleeping, or "dead", than to be confronted with the survival threat and its attendant fears.

The Mechanism of Insomnia

Confronted with a threat especially with a lifetime of accumulated stress, the patient enters Survival mode with the Flight or Fight Response. This results in the release of cortisol, adrenalin and other hormones and neurotransmitters with the specific task of empowering survival.

Two main effects result: Firstly this response is mentally, emotionally and physically exhausting. The thinking, logical, objective mind is inoperative for all energy is geared to and focussed on survival. Secondly, one cannot sleep! For thousands of generations, the instinct for survival has been ingrained in humankind – we are designed to remain awake and alert to combat this perceived danger to our surroundings, family or ourselves.

If there is a sabre tooth tiger prowling outside the cave or a warring tribe laying siege, nobody

sleeps! We must stay awake when threatened! This response has ensured the survival of the species. Despite the utter mental and physical fatigue, the subconscious must maintain this survival mode: sleep would place the individual in danger of death and must be avoided.

In therapy, the vital point of understanding is that there is no real threat in the present situation! The patient is responding to a consciously long-forgotten threat that no longer exists! The subconscious is still responding to this memory as at that time it had no way of knowing the original threat was survived! Hence, it must continue the protection (9).

Long experience indicates that the original threat was very early in life – usually the birth experience (4-6). This situation when the symptom arises is usually the time when a sedative hypnotic is prescribed. However, a conflict now arises! The subconscious must ensure wakefulness to combat the "threat" yet we now supply a powerful sedative in direct opposition to this imperative!

This sedation supplied by means of a sleeping tablet will work… the patient copes, for a while. However within weeks or perhaps longer, the patient finds that one tablet does not bring the same degree or length of sleep. The patient often increases the dose without supervision or the clinician increases it. All is again "well" for a time when the same sequence occurs–the dose is again increased. The subconscious is fighting the sedation, reducing its efficacy because it must ensure alertness! This is the basis for the development of tolerance–every clinician has seen this phenomenon. The patient is now one step away from a true physiological addiction–iatrogenic disease: caused by the doctor. Worse still, the sleep disturbance is still present and the patient is worse off than before.

Despite statutory warnings of the dangers of medication for more than some weeks, this remains a universal problem. Clinicians, without other effective means of managing their patients, have now entered into collusion with the patient. Sometimes rather radical means are used to overcome this impasse–up to and including Electroconvulsive Therapy or sleep therapy. All this achieves is a temporary respite… the subconscious problem is still banked in memory and it will surface again despite these costly procedures that are not without morbid risk.

THE PLACE OF HYPNOSIS

It is becoming more evident that Clinical Hypnosis is a safe and effective method to provide assistance to insomniacs. More pertinently, it allows us access to the real problem!

This approach may follow one of two methods.

Direct or Indirect Suggestion (10)

My personal opinion is that these are quite satisfactory in the short term. However as in the case of medication, should there be a powerful subconscious reason to remain alert, one can expect recurrence of the insomnia or some alternative symptom to arise as the subconscious strives to maintain alertness. These are usually somatic in nature and their significance go unrecognised as the association is missed. Typical comments are "Oh well, you now have asthma-of course you can't sleep through." The asthma is the alternative symptom produced by the subconscious, providing the "excuse" to remain awake.

It is my experience that in many patients, the new symptom is often worse, even more dangerous, than the insomnia.

Hence, I do not consider Direct or Indirect Suggestion to be adequate–indeed I am wary of the potential consequences.

Analytical Hypnosis

There is no doubt that these methods are far

more effective, long-lasting and avoid alternative symptoms.

If one accepts the premise that the insomnia is a signal for assistance, that the insomnia is there for the purpose of survival, it is incumbent on a clinician to recognise that threat or psychic pain and to treat it as the real problem.

Failing to do so is very much like putting water in a car's leaking radiator, hoping that somehow it will seal itself. It is not the engine's overheating that is important–it is the hole in the cooling system.

There are a number of analytical techniques but the commonest are:

- Traditional Hypnoanalysis
- Ego State Therapy
- Medical Hypnoanalysis

Since the last mentioned is the author's main field of expertise, some elaboration is now provided.

Medical Hypnoanalysis (MHA)

In brief, Medical Hypnoanalysis is a structured, short term, directed modality utilising regression as its chief tool. The Triple Allergenic Theory indicates that the symptom is the result of a cascade of events beginning with an event not consciously remembered, known as the Initial Sensitising Event or ISE. The 'seed' of the symptom is planted in the subconscious with this event and is related to the "unholy trinity" of Anxiety, Fear and Guilt (4-6).

In the course of Life, a further threatening event is experienced that powerfully recalls the thoughts and emotions of the ISE and now, for the first time the symptom is produced. This event is known, logically, as the Symptom Producing Event (SPE). However the symptom at this time is mild and transient. It will resolve without any intervention. A further event – the Symptom Intensifying Event or SIE–results in exactly that: an intensification of the symptom complex. The symptom is now more severe and lasts longer. Subsequent SIE's will result in escalation of the discomfort and duration of the symptom–yet, it remains only as the subconscious reaction to the ISE… with a far higher voltage. This is the basis of the Triple Allergenic Theory–an analogy being the development of an allergy to bee stings and the venom introduced into the patient's body. With each event, the "emotional antibodies" gain more power until a symptom arises. Each event involves an emotional 'flashback' to the original event. In effect, a symptom is an abreaction of the train of thought, the emotions and subsequent behavioural mechanism established in the ISE (4,5).

In order to eradicate this sequence, it is necessary to explore the original event and desensitise its emotional impact. When this is achieved, the symptom will disappear. Medical Hypnoanalysis is so termed because it follows a medical model: a very detailed History is taken, noting the verbal and non-verbal responses that are indicating the original event.

This is followed by an Examination in trance by means of a specifically designed Word Association Test – in which the subconscious is provided the opportunity to confirm what has been learned in the history. It also may bring to light material missed in the history and provides information of the resources of the patient as well as the purpose of the symptom. Investigation is achieved through dream analysis, the three-box test and other hypnotic techniques. A firm Subconscious Diagnosis can now be made–and there are but six of these. They differ from conventional medical or psychiatric diagnoses in that they are descriptive in nature and assist the patient to understand the underlying dynamics and effect a cure from within.

The Subconsious Diagnose:

The Pre-Natal Experience (PNE)

The perceptions by the fetus of intrauterine events and their emotional impact of faulty belief systems.

The Identity Problem (IDP)

This is a loss of a sense of meaning, purpose

and belonging usually as the result of a perceived or actual absence of Love. This results in a spiritual void (5,6).

The Death Expectancy Syndrome (DES)

The expectation of death in an encountered situation which is the basis for future Fear and Anxiety. Most commonly established in the birth process where it is known as the Birth Anoxia Syndrome (11,12).

The Walking Zombie Syndrome (WZS)

Essentially, a subconscious acceptance of physical death or the idea that life is no longer worthwhile. This is a state of empty death-like existence and characterises depression. However, the subconscious mind must now find a method of demonstrating that life continues–known as the Proof of Life–this is the basis fro the symptom (4).

The Jurisdictional Problem of Guilt (JDP)

A self-imposed theological or spiritual guilt with a fear of divine rejection and results in self-punishment. Any anxiety syndrome not resolved by eradication of the Death Expectancy Syndrome indicates unresolved guilt: the fear of God's rejection supersedes all physical fear (13).

The Ponce de Leon Syndrome (PDL)

This indicates an age immaturity problem where a person has had his or her normal maturation arrested at a particular age as the result of a traumatic life event in childhood. This person cannot grow older as the belief is that to do so will invite death (14).

The Process of Medical Hypnoanalysis

Rapport
Relaxation in trance
Regression to the identified events
Realisation of the faulty beliefs
Removal of the faulty beliefs
Replacement with the truth–positive belief
Rehabilitation of the old negative train of thought, emotion and behaviour
Reinforcement of positive responses to life events in the future.

CASE STUDY

History

The patient is a 43 year old male with a history of insomnia for the past three years. He had been using hypnotics for most of this period and was now taking three tablets at night. He was also taking an adequate dose of a selective serotonin reuptake inhibitor. He had associated symptoms of anxiety.

On being asked: "What is the problem?" he replied with a big sigh and said:

"It just seems I've never been able to sleep. Something always happens–a noise, a thought and then that's that–it's finished. I've always been a nervous kind of person but now I'm really worried about becoming an addict."

Comment:

His "sigh" is an indication of breathing–and is a non-verbal reference to an event when he could not breathe.

He refers to the birth experience with the use of the word "always" twice and once using the word "never". These are subconscious references to the very beginning of his life. His "nervousness" is the Death expectancy Syndrome.

He has also indicated his Walking Zombie Syndrome in that he has given up on his ability to live–he states: "that's that–it's finished".

We therefore are already aware of the Initial Sensitising Event (ISE)–his birth. He confirmed this in the history by saying he had had a difficult birth and was in an incubator for some hours because he was blue. Noteworthy here is the fact that bonding with his mother was delayed – there was also a probable Separation Anxiety.

The Symptom Intensifying Event was easily

established. Shortly before his onset of insomnia his wife had left him and they had divorced. He became depressed and his business suffered–he had thus experienced a loss of Love and self-esteem and was threatened socio-economically. Both of these are perceived by the subconscious as "death threats".

The Word Association Test

The above was all confirmed in the Word Association Test:

My problem=can't sleep
Not sleeping protects me from=the unknown
The colour of my problem=black
The colour black means to me=death
The emotion of my insomnia=fear

His real problem is therefore the fear of death! The origin of this fear is confirmed in the Word Association:

When the walls close in=fear
Breathe=life
Suffocate=panic
If I don't get out=die

This is part of the 'birth sequence' of prompts–clearly he believes he will die if he can't get out and escape the threat. Also,

My greatest fear=to be alone
Loneliness=fear
When my wife left=fear

Thus, his wife leaving allowed the fear of loneliness, i.e. the fear of death to recur with a high emotional voltage. There is no physical threat – yet the subconscious does not differentiate: this is DEATH!

His Symptom Producing Event was found in the Word Association:

It all started when = I was 4

We knew from the history that he had had a tonsillectomy at the age of four years under general anaesthesia, induced by gas via a mask.

Regressions

His first regression was to the birth experience where the typical features of compression in the birth canal were felt, especially on his head and chest. He had an overpowering compulsion to breathe with a high voltage of fear. On asked what he was afraid of, he replied: "I'm going to die". There was a long and helpless, lonely struggle through the birth canal during which time he reached the conclusion he was indeed dying–this was the Walking Zombie Syndrome which followed the Death Expectancy Syndrome.

He was encouraged to progress to birth and his first breath that confirmed to him he was alive! With this knowledge, he was able to delete the faulty thought of his death and eradicate this past and now useless fear.

It was also necessary for him to understand the separation from his mother while he was in the incubator, for, once it can breathe, a baby has three needs–food, warmth and above all, LOVE! This delay in bonding was the seed for his perceived death threat when his wife left! With the reassurance of the bonding love with his mother, he was now safe and could eliminate his fear of abandonment.

The Symptom Producing Event at four years of age resulted in the same train of thought, emotions and behaviour. He was taken from his mother to the theatre where 'they' applied a mask to his face–he felt he could not breathe, that he'd been abandoned again into a dangerous situation and as the gas took effect and the darkness of anaesthetic sleep descended, he again believed he was dying.

With the Symptom Intensifying Event of his marital separation, he was already conditioned to his old established subconscious reactions–fear and death. To avoid that perceived potential death; his subconscious was compelled to keep him awake–lest he died again in the birth and with his tonsillectomy! His insomnia now arose and persisted.

Rehabilitation

This was largely achieved during the course of the regressions–all that remained was to use metaphors to assist the subconscious mind to accept he was indeed alive, safe and loved, and to empower his relaxation response. Using progression he was able to imagine himself laughing himself to sleep with the old child-like reactions no longer active!

Result

This patient made a full recovery not only from his insomnia but also his anxiety and depression. The process took ten one-hour sessions and he rapidly was weaned off his hypnotic drugs under supervision of his own doctor in consultation.

DISCUSSION

An overall discussion is presented to include the current conventional thinking in insomnia as opposed to the knowledge we now have and utilise in current practice in Clinical Hypnosis. A brief case discussion is included to illustrate the direct approach to the real problem instead of ignoring the obvious–with a view to cure as opposed to coping.

It is a tragedy that traditional medicine, psychology and health care providers are ignorant of the huge benefits provided by clinical hypnosis–this is partly due to poor research coordination and publication, poor marketing and partly due to resistance. There are at least perceived threats to a major industry involving many millions of dollars! This industry, I suggest, promotes "coping." At the same time, the health professions as a whole are ignorant of the probability of achieving a cure using clinical hypnosis despite co-morbidity. It is clear that astute trained use of appropriate clinical hypnosis is of great advantage to patients–and this is, first and foremost, where our duty lies.

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