INSOMNIA AND PSYCHOTHERAPY

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This article gives a brief overview of some approaches to treat insomnia using psychotherapy.

Keywords: insomnia, psychotherapy

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Introduction

Sleep is important for the maintenance of mental health, and a sleep disturbance is usually an important signal indicating the presence of a mental health condition. Sleep is abnormally reduced or increased in depression, for example, similar to abnormal changes in appetite. But sleep disturbance also has a direct effect on mood, anxiety, manic states, episodes of psychosis and more.

Subjectivity

There is no optimal sleep duration that works for everyone. Some people need more sleep, others less. The duration that is required by one person to feel well the next day may be too much already for another person. Rather than the sleep duration, it is certain patterns of the sleep-wake cycle that signal a sleep disturbance, as well as the symptoms that are usually associated with sleep deprivation, for example. According to a theoretical model described by Lundh and Broman (2000), there are two broad categories of processes that are involved in the development and maintenance of insomnia:

- sleep-interfering processes
- dysfunctional sleep-interpreting processes

The second can be misperceptions of sleep, as well as dysfunctional beliefs, expectations and attributions concerning sleep and the causes and consequences of poor sleep. According to this model, primary insomnia is the result of an interaction between these two kinds of processes, as manifested in various kinds of “vicious cycles of sleeplessness” (Broman & Lundh, 2003; Lundh, Lundqvist, Broman, & Hetta, 1991), whereby sleep-interfering and sleep-interpreting processes mutually reinforce each other.

Psychodynamic Considerations

An important first step is to ask why a patient is suffering from insomnia. There can be several reasons that underlie the various psychological processes that directly interfere with sleep. In many cases, something is 'out of sync' in the life of the patient, whether in the professional or private realm. T may be emotional conflicts or conflicting thoughts which lead to the feeling that something in life is not working as it should. This can, of course, cause other symptoms as well from a wide spectrum of mental health conditions.

Awareness and insight can be helpful in finding the underlying causes of the insomnia. A focus on interpersonal communication patterns, fears and anxieties can be helpful. (Haverkampf, 2010, 2017)

Cognitive Behavioral Approaches

Methods may focus either on sleep-interpreting processes (e.g., by means of Socratic questioning or other forms of reality testing of sleep-related beliefs) or on sleep interfering arousal processes (e.g., by means of physiological or cognitive arousal-reducing methods)—the important thing is not where in the vicious cycle the intervention is made, but that the intervention is sufficiently powerful to break this cycle.

Sleep Restriction Treatment

The stimulus control procedure that introduced by Bootzin (1972) more than 40 years ago was a helpful contribution in the treatment of insomnia. However, the introduction of sleep restriction treatment (Spielmann, Caruso, & Glovinsky, 1987) and cognitive methods (Morin, 1993) have not so far demonstrated any increase in the effectiveness of treatment.

Acceptance and Mindufulness

Acceptance and Mindfulness (e.g., Hayes, Strosahl & Wilson, 1999; Linehan, 1993; Marlatt, 1994; Segal, Williams, & Teasdale, 2002; see Baer, 2003 for a review) have become an integral part of the therapeutic CBT repertoire. They have now also been applied with some success to cases of insomnia (Heidenreich, 2003; Lundh & Hindmarsh, 2002; Shapiro, Bootzin, Figueredo, Lopez, & Schwartz, 2003). A combination

of mindfulness practice and psychoeducational methods may promote cognitive deactivation and acceptance, and better sleep.

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An approach combining mindfulness and acceptance focuses on sleep-interfering cognitive processes, such as

- an excessive reliance on verbal regulation of behavior
- controlled information processing

may be more helpful than just focusing on cognition or on mindfulness and acceptance.

Communication-Focused Therapy (CFT)

As already mentioned above, CFT as developed by the author can be an important tool in working with patients suffering from insomnia. Important is to help patients distinguish between thought streams in their mind and perceptions of the physical world around them. Fears and anxieties around sleep are quite often due to a misinterpretation of internal communication as being a true reflection of the real world. This tends to occur frequently also in obsessive thoughts and ruminations interfering with a patient's sleep.

Working with the external communication patterns in therapy helps to change internal communication and the patterns that lead to the unhelpful perspectives which can lead to insomnia. The fears, anxieties and loss of control, as well as the ruminations, that keep from sleeping are linked to how information from

outside or within the person is processed. Better internal communication patterns can thus be helpful in improving sleep.

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Sleep is not just being away from things, but it is a state in which change happens. Dreams are the product of information processing in the brain and the deep relaxation that comes with most phases of sleep helps the body to regenerate for a new day ahead. Unfortunately, sleep often becomes a problem when there is not too much to look forward to on the next day. Focusing on identifying what is important, relevant and meaningful to the person in CFT can help to divert the focus from the sleep, where it often just causes more insomnia, to the aspects of life that can motivate.

Sleep

Sleep is a naturally recurring state of mind and body, characterized by altered consciousness, relatively inhibited sensory activity, inhibition of nearly all voluntary muscles, and reduced interactions with surroundings. It is distinguished from wakefulness by a decreased ability to react to stimuli but is more easily reversed than the state of being comatose. Sleep occurs in repeating periods, in which the body alternates between two distinct modes known as non-REM and REM sleep. Although REM stands for "rapid eye movement", this mode of sleep has many other aspects, including virtual paralysis of the body. A well-known feature of sleep is the dream, an experience typically recounted in narrative form, which resembles waking life while in progress, but which usually can later be distinguished as fantasy.

During sleep, most of the body's systems are in an anabolic state, helping to restore the immune, nervous, skeletal, and muscular systems; these are vital processes that maintain mood, memory, and cognitive performance, and play a large role in the function of the endocrine and immune systems. The internal circadian clock promotes sleep daily at night. However, work shifts at night, artificial lighting and the

increased use of smartphones and reading devices in bed are having their effects on the sleep-wake cycle. Many of these factors are only under a person's limited control, and it is usually more helpful to consider the meaning and relevance sleep has to oneself. It is not even the sleep that matters to most people but what sleep does and does not do for oneself. Many patients focus on sleep as the main problem, while this is only one aspect in their life, and other aspects may have a greater impact on life. But rather than focusing on the issues that have a direct impact on the quality of life, the focus is shifted to another issue, such as sleep, which only has an indirect effect. Insomnia is after all always a sign that something is not working or 'out of sync'. The focus in CFT is on finding ways the patient can better communicate with himself and others what may be 'out of sync'. The basic approach is to create awareness for and insight into internal and external communication patterns and make changes. This also changes what information is received from the inside and outside word, and how this information is processes. In the case of sleep disturbances, where misinterpretations of sleep and misattributions of symptoms and sleep effects are frequent, these changes can be very helpful in clinical practice.

Sleep Control

There is frequently a misperception about the aspects of sleep which one can control and which are not under a person's control. Sleep fluctuates as the result of various kinds of external and internal events (stressful events, emotional concerns, etc.), which may seem beyond one's control or influence. However, often people find out within a therapy that they have more influence over these external events than they think, and in particular the influence one has over the own interpretation of these events is often underestimated.

Sleep is not under voluntary control, and there are no techniques that can be used efficiently in order to fall asleep, so these fluctuations have to be accepted. Sleep may be improved by learning new skills and habits, but this is a process that leads to effects over time and is not a matter of using techniques in order to fall asleep. However, even a sleepless night is no catastrophe. "Even if I will get no sleep at all tonight, I will still manage tomorrow." Anyway, a poor night's sleep is generally compensated for by deeper and more refreshing sleep (i.e., increased delta sleep) the coming nights.

Deactivation and Activation of Processes

Sleep is facilitated by a cognitive deactivation, which involves less of verbal regulation and control as compared with daytime functioning, and correspondingly more of acceptance of spontaneously occurring physiological and mental processes. This perceived yielding of control can be difficult for many individuals suffering from insomnia. It is the result of how a person defines control. If control is just seen as an act of consciousness, which many people learn in school or at their workplace, then the process of falling asleep and losing consciousness becomes something to be dreaded. Especially if there is a high need for cerebral control in a person, creating awareness for the automatic communication processes in the world which maintain life can bring about a relief and better sleep. For many patients who suffer from anxiety and OCD this perspective can be quite liberating.

Healthy pre-sleep processes (i.e., processes that are conducive to falling asleep either during the initial sleep-onset period or after awakening) involve a cognitive deactivation, in the sense of a decrease in the person's controlled, strategic information processing, paralleling a corresponding physiological deactivation (e.g., a decrease in muscle tone, a slowing of the heart and respiration rates, and a reduction in blood pressure). To the extent that this cognitive deactivation does not occur, but the individual's mental processes remain dominated by verbal thinking and controlled information processing, this will interfere with sleep.

Lundh and Broman (2000) have argued that insomnia is an interaction between sleep-interfering and sleep-interpreting processes. Harvey (2002b) focused on sleep-interpreting cognitive processes, such as

- perceptions of sleep
- beliefs about sleep
- sleep expectations

Information Processing

The network of nerve cells in the brain primarily processes information by communicating information from one point to another and by changing packets of information in the process. These mechanisms

make thinking, perceiving, sensing and communicating with the outside world possible. The fact that information is processed differently while a person sleeps usually does not cause the insomnia, but how a person experiences the change from one processing mode into another. As mentioned, if this change is experienced as a loss of control by an individual, and this control is important to the person, sleep can be associated with fear and dread, resulting in psychological insomnia.

People's activity levels show considerable diurnal fluctuations, not only with regard to physical activity but also in terms of purposive goal-directed cognitive activity (i.e., controlled strategic information processing). While awake, most people engage in controlled information processing more or less continuously, as part of various kinds of purposive activities, like problem solving and decision making. If some people are less able to disengage from their daily concerns, and to let go of controlled information processing, this will inhibit their sleep-promoting dearousal processes (Espie, 2002). Further, it may be expected that these individuals will be less able to deactivate their controlled information processing also in other situations of rest.

Unhelpful Mental Strategies

Levels of metacognitive control, metacognitive awareness, negative affect, and alertness seem to be relatively stable aspects of individual functioning, which do not differ in any radical fashion from the daytime rest situation to the nighttime pre-sleep situation. Thus, approaches that can interrupt worrying, rumination, and other kinds of sleep-interfering cognitive processes during the day can also improve sleep.

Acceptance

Acceptance means not trying to change something where it is

- Not possible to change anything and/or
- Not helpful to change anything

Insomnia interferes less with one's life if one makes it less of an issue. This works especially well in cases of reactive or stress induced insomnia in combination with other psychotherapeutic approaches. In cases of more severe insomnia, a comprehensive psychotherapeutic approach is usually needed, often in combination with medication.

During the last decade, acceptance has become a central concept in several new forms of cognitive-behavioral therapy, the most important of which are Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) and Dialectical Behaviour Therapy (DBT; Linehan, 1993). A main theme in these therapies is that, whereas strategies for controlling events and achieving change are functional in many areas of dysfunctional behavior, acceptance is the most functional approach in others—as for example when the dysfunctional process consists of thoughts, emotions, or memories. "Experiential avoidance" (i.e., avoidance of thoughts, feelings, memories, etc.), in fact, is regarded by Hayes and colleagues (1999) as one of the main causes of human psychopathology.

According to Hayes and colleagues, experiential avoidance is an example of the verbal overregulation of psychological processes. Verbal regulation of behavior clearly is an example of controlled information processing.

Research on thought suppression, worrying, and rumination seems consistent with the claim that some kinds of psychopathology may involve a verbal overregulation of psychological processes. For example, experimental research indicates that deliberate thought suppression—a prime example of verbal regulation of thought processes—tends to produce an increase in the suppressed thoughts (Wenzlaff & Wegner, 2000). Borkovec's (1994) research on generalized anxiety disorder similarly implies that the chronic worries that are typical of GAD patients represent an overreliance on a verbal thinking, and a suppression of imagery, affect, and emotional processing. Another example that strongly points in the same direction is Nolen-Hoeksema's (2000) research on the role of verbal rumination for the development and maintenance of depression, and of mixed depression/anxiety states.

There is accruing evidence that verbal overregulation and avoidance may be important maintaining processes in insomnia. In a questionnaire study, Harvey (2001) documented that people with insomnia generally report more of metacognitive thought control strategies, in particular thought suppression, reappraisal, and worrying than good sleepers. In a second experimental study, Harvey (2003) the results

showed that participants who were instructed to suppress their thoughts reported longer sleep latencies and poorer sleep quality than participants given nonsuppression instructions. She therefore concluded that active control strategies in the pre-sleep situation may be maladaptive and that the process of falling asleep should involve minimal effort. Lundh and Hindmarsh (2002) similarly found that the degree of metacognitive control, as measured by the daytime CEST, correlated with longer sleep latency, shorter sleep time, and lower sleep satisfaction. This corroborates the hypothesis that controlled information processing, at least when it takes the form of metacognitive control, is associated with sleep problems.

Higher degrees of rumination also seem to be associated with longer sleep latencies and poorer sleep quality, even when controlling for negative mood (Thomsen, Mehlsen, Christensen, & Zachariae, 2003). Further evidence that people with insomnia are involved in excessive verbal thinking that is counterproductive both with regard to sleep and daytime functioning was contributed by Nelson and Harvey (2002, 2003). In one study, they found that verbal thinking about stressful matters during the pre-sleep period was associated with longer sleep latencies and more anxiety and discomfort the next morning, as compared with thinking about the same stressful matters in terms of mental images (Nelson & Harvey, 2002), and in a second study they found that patients with insomnia showed less pre-sleep imagery than good sleepers (Nelson & Harvey, 2003).

Attempts at verbal regulation of cognitive processes whilst trying to get to sleep seem clearly dysfunctional. It is difficult to fall asleep by telling oneself to do so, and all kinds of strategies for falling asleep have the potential of backfiring if the efforts involved lead to an increased arousal. The research reviewed above adds to this picture by strongly indicating that attempts at verbal regulation of cognitive and emotional processes in the pre-sleep situation are also likely to be dysfunctional. What would seem to be functional in the pre-sleep situation is an increased reliance on spontaneous (i.e., not verbally regulated) processes of physical and mental relaxation and mental imagery.

In Hayes and colleagues' (1999) Acceptance and Commitment Therapy (ACT), the therapist begins the process by focusing on three primary questions:

1. What does the client want?
2. What has the client tried? and
3. How has that worked?

That is, one of the first goals in the initial assessment phase is to enumerate all of the various methods that the client has used and how they have worked. According to Hayes's model, this often leads to the identification of a class of futile control strategies that have not worked—an "unworkable change agenda." The next goal is then to introduce an alternative to these control strategies, which Hayes refers to in terms of "acceptance." This kind of approach may be suitable in the treatment of insomnia, because sleep problems represent a paradigm example of a problem where control strategies are bound to fail. This means that the assessment of insomnia should include a detailed review of all kinds of techniques that the client has tried in order to improve his or her sleep. This will most probably lead to an identification of a class of goal directed control strategies that have not worked very well, and which can be the starting point for looking at alternatives that involve more of acceptance.

Another concept from ACT that may be relevant to insomnia is "cognitive defusion," or "deliteralization," which means becoming aware of one's thoughts as thoughts, and is seen as a key intervention in ACT. As Hayes and colleagues argue, "eliciting difficult experiences allows them to be observed and studied experientially" in a stance of "nonjudgmental detachment." A basic point here is that dysfunctional beliefs and negative automatic thoughts are not evaluated as something negative to get rid of. One reason for this is that evaluations of this kind risk fueling vicious cycles of having negative automatic thoughts about one's negative automatic thoughts. As the authors formulate it: "ACT undermines evaluation in an interesting way: by reducing the dominance of language itself. ACT does not evaluate evaluation. It does not say, 'You shouldn't say should' or 'It is bad to say bad.' Instead, ACT tries to open the window and let a little (nonverbal) air in" (Hayes et al., 1999, p. 76). A pilot study of an ACT-inspired group treatment of insomnia has recently been carried out with promising results (Åkerlund, Bolanowski, & Lundh, 2004).

It is important to note that all methods for the treatment of insomnia, including mindfulness exercises and acceptance techniques, may be drawn into potentially self-defeating attempts to fall asleep by means of controlled efforts—that is, they may all be used as techniques for the explicit purpose of falling asleep more or less instantly. One way of counteracting counterproductive efforts of this kind in the treatment of insomnia is to use "counter-demand instructions" (Steinmark & Borkovec, 1974) as part of the rationale, that is, to instruct the patient that no improvement is to be expected during the first weeks of treatment. Most importantly, however, the patient may be instructed that treatment is a matter of learning new skills—which is a process that takes time—and not a matter of finding techniques that can be used instantly to fall asleep. For example, if the CEST procedure is included in treatment packages for insomnia,

care should be taken that the procedure is not used as a technique in order to fall asleep instantly. Helping the Client Construct a New “Schematic Model” of Sleep and Sleeplessness

If acceptance and mindfulness techniques are applied to patients’ pre-sleep processes, this may also contribute to a relearning about sleep and the contingencies of falling asleep. For example, mindful observation of these processes may be assumed to lead to the perception that pre-sleep processes and sleep fluctuates naturally as the result of various kinds of external and internal events (stressful events, emotional concerns, etc.), and to a more elaborated belief that sleep is not under voluntary control and that these fluctuations must therefore be accepted. The use of acceptance and mindfulness techniques may thereby also help to change dysfunctional sleep interpreting processes that are common in insomnia. In addition, it may also be useful to help make these perceptions more explicit with the help of Socratic questioning, behavioral experiments, and other psychoeducational methods.

Mindfulness

Mindfulness is a practice of nonjudgmental observation of processes, which can also include the own mental processes. It helps to prevent from getting caught in loops of worrying, for example. Many patients who suffer from insomnia find learning mindfulness very helpful. It is essentially a change in internal communication patterns as is also the focus in communication-focused therapy (Haverkampf, 2017). Once one has a greater awareness for the flows of information and the communication patterns inside oneself, getting caught up in an emotional loop becomes less likely.

The current mindfulness literature describes numerous meditation exercises designed to develop mindfulness skills (e.g., Kabat-Zinn, 1994; Linehan, 1993; Marlatt, 1994; Segal et al., 2002). Mindfulness is practiced with an attitude of nonjudgmental acceptance. Perceptions, cognitions, emotions or sensations that enter the individual’s awareness during mindfulness practice are observed carefully but are not evaluated as good or bad, true or false, healthy or sick, or important or trivial. From a communication perspective it is important to add to acceptance the ability to observe communication patterns, which also helps in bringing about acceptance.

In the CFT modification of mindfulness, the individual becomes more active in identifying certain internal communication patterns as 'thoughts' which are distinct from the reality of other forms of communication, such as an interaction one has at the post office or at work. Internal thoughts and information received from the perceptions of an interaction with another in the external world are all forms of communication, the transfer of meaningful information, but they need to be distinguished. In patients suffering from anxiety or psychosis this distinction gets lost, which causes many of the symptoms that interfere with everyday life. CFT focuses on the ability to recognize and identify communication patterns. (Haverkampf, 2018)

Yielding control can actually lead to increased control over one's sleep. If there is already a fear of loss of control over important areas in one's life to begin with, yielding control to improve one's sleep may seem counterintuitive. However, this is often an important component of therapy.

The difficult part about mindfulness is to enable oneself to selectively disengage, because total disengagement is often not desired. In order to understand processes – and not just see them – we have to engage with them. However, the selection process requires some engagement. An easy solution to this conundrum is to develop a sense for when is a good time to let go, which may be the most important skill, but requires considerable insight and reflection about oneself.

Shapiro and colleagues (2003) applied Kabat-Zinn's model for mindfulness-based stress reduction (MBSR) to sleep problems in a group of women with breast cancer. Although there was no significant difference between the mindfulness group and a control group on sleep measures, the results showed that participants who reported greater mindfulness practice reported significantly improving sleep quality. It should be noted, however, that this treatment was not adapted for sleep problems but involved a general training focused especially on mindful breathing. In an uncontrolled study, Heidenreich (2003) used a mindfulness approach that was more specifically adapted for insomnia patients, and which combined Kabat-Zinn's model for mindfulness training with a cognitive model for insomnia, along the same lines as described by Segal and colleagues (2002) in the treatment of depression. The results showed significant decreases in problematic cognitive activity, as well as a significant increase of total sleep time and a decrease in sleep latency in a group of 14 insomnia patients. Because there was no control group, however, no firm conclusions about the effectiveness of this treatment model can, as yet, be drawn.

Trauma

Flashbacks at night are often a terrifying symptom of trauma. They can make the experience of sleeping an anxiety provoking experience and lead to avoidance of it as much as possible. This may also involve the abuse of alcohol and other addictive substances to initiate sleep, which over the long-term leads to more sleeplessness, anxiety and fears. To break this vicious cycle early on is an important part of therapy.

Trauma related to childhood sexual abuse (CSA) is associated with psychiatric and interpersonal difficulties during adulthood, including depression and anxiety (Kendler et al., 2000). Less attention has been focused on insomnia, the difficulty of initiating and maintaining sleep, in the context of CSA. In general, insomnia is strongly linked to depression (Pigeon & Perlis, 2007) with approximately 90% of individuals with major depressive disorder (MDD) also experiencing sleep disturbances (Riemann & Voderholzer, 2003).

Insomnia symptoms tend to persist following various treatments for MDD including medication treatment (Menza, Marin, & Opper, 2003), cognitive behavior therapy (CBT; Carney, Segal, Edinger, & Krystal, 2007; Manber, et al., 2003), and stepped care depression management (Pigeon et al., 2008). This evidence suggests that insomnia may not reliably improve with these forms of depression treatment.

A growing body of literature suggesting that insomnia symptoms accompanying psychiatric disorders may not fully ameliorate in consort with the primary disorder. This is especially germane since insomnia is associated with chronic illness, lower quality of life, increased probability of relapse and recurrence of MDD, and increased suicide risk (Menza et al., 2003). For CSA survivors in particular, the sleep environment may be uniquely associated with insomnia if the sexual trauma occurred in a sleep context. Consequently, hyperarousal and hypervigilance may become a conditioned response to the bedroom, and sleep may be perceived as dangerous because it restricts the ability to monitor one's surroundings (Craske & Tsao, 2005). These trauma-specific manifestations of insomnia along with the high prevalence rates of insomnia in traumatized populations make apparent the need for a sleep assessment in patients presenting with trauma histories.

When insomnia persists following conventional treatments for MDD and/or PTSD, a targeted insomnia intervention may be required. Preliminary evidence has shown CBT for insomnia (CBT-I) to be effective in alleviating insomnia among patients with PTSD (DeViva, Zayfert, Pigeon, & Mellman, 2005; Germain, Shear, Hall, & Buysse, 2007).

Change in Perspective

If the goal that is to be reached requires a relaxed state, increased efforts and tension are counterproductive and may even make it more difficult to reach the goal. Paradoxically, therefore, if a person tries to relax in order to fall asleep or tries to fall asleep by means of carrying out mindfulness exercises, this may in fact create a tension or arousal that makes it more difficult to fall asleep. Moreover, if a person fails to reach the desired goal, he or she may become frustrated in a way that increases tension and arousal even more. To help the patient get a label on this process, this phenomenon may be referred to as “trying too hard to fall asleep.” Often people end up fighting their insomnia, and thus themselves, which causes self-blame, disappointment, helplessness, hopelessness, and a decrease in self-confidence and mood. Rather than making the insomnia an even greater issue, the solution is to make it less of an issue.

Breaking a Vicious Cycle

The perception and interpretation of insomnia as a major problem can lead to increased anxiety, and thus increased arousal, which makes sleep even harder. To the extent that the attempt at trying to control one’s sleep mentally, and especially verbally, is a problem, acceptance- and mindfulness-based interventions may be indicated. The rationale for this is that these techniques may help foster a more accepting approach to spontaneously occurring physical and psychological processes, which may help to promote sleep.

Variations

It should be remembered, however, that insomnia patients present with a large variety of different clinical pictures, and that treatment should always rest on a functional analysis of the specific person's sleep problems (Lundh, 1998, 2000), and the techniques used have to fit the individual patient. If there are psychodynamic issues that need to be resolved, a focus on relaxation will not accomplish much, and if there is primarily a learned maladaptive strategy to fall asleep, focusing primarily on a patient's psychodynamic issues will not accomplish much.

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