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Hypnosis: An Alternate Approach to Insomnia

SUMMARY

Insomnia, the feeling of inability to go to sleep or to stay asleep, is a pervasive clinical problem. This paper examines the relationship and similarities between sleep and hypnosis. Research on the study of EEG patterns during hypnosis shows that many authors feel hypnosis is a waking phenomenon. Why hypnosis allows for the induction of sleep is not clear.

Primary and secondary sleep disorders are classified. Primary disorders have an autonomous function in the central nervous system while secondary disorders can result from depression, pain, anxiety, lifestyle change, etc. Secondary disorders are most likely to be improved by hypnotherapeutic techniques, which include progressive relaxation and ego-strengthening. (*Can Fam Physician* 1982; 28:768-770).

SOMMAIRE

L'insomnie, cette incapacité de dormir ou de demeurer endormi, est un problème clinique qui se fait sentir un peu partout. Ce document traite de la relation et des similitudes qui existent entre le sommeil et l'hypnose. On y fait part d'une étude sur des électro-encéphalogrammes et un survol des textes sur le sujet démontre que bon nombre d'auteurs considèrent l'hypnose comme un phénomène d'éveil. Les raisons pour lesquelles l'hypnose peut provoquer le sommeil demeurent confuses.

Les troubles de sommeil primaires et secondaires font l'objet d'une classification. Les troubles primaires sont d'origine cérébrale tandis que les troubles secondaires peuvent être causés par une dépression, de la douleur, de l'anxiété, un changement de mode de vie, etc. Les troubles secondaires sont plus susceptibles d'être traités, avec succès, avec des méthodes thérapeutiques par l'hypnose qui comprennent le relâchement progressif et le renforcement du moi. Le sommeil chez les patients qui ont de la douleur peut être amélioré grâce au relâchement progressif et à l'utilisation de l'anesthésie subjective de la main. Le renforcement du moi est une forme de pithiatisme qui peut résoudre les problèmes d'insomnie reliés au stress et à l'anxiété.

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INSOMNIA, loosely considered as the feeling of inability to get to sleep or to stay asleep, is one of the most pervasive complaints in family practice.¹ It is associated with many clinical entities, from infection and chronic lung disease to hyperthyroidism and depression.

Many approaches to treatment have been taken by all kinds of practitioners (family physicians, psychiatrists, social workers, psychologists, pastoral counsellors, chiropractors,

health food promoters) to overcome the problem of insomnia. It seems everyone has a cure. Most doctors probably recommend a pharmacological approach consisting of sedatives and antidepressants. Sleepless physicians themselves probably use the proverbial night cap, brandy or wine. Behavioral training counsellors rely more on changes in diet, reading, increased exercise and/or sex, counselling and various types of programs such as biofeedback autogenic training, and progressive relaxation.²

Use of Hypnosis

Historically, the term hypnosis derives from the Greek "hypnos" (to

sleep).³ To the casual observer the hypnotized subject appears asleep.

There are many similarities between sleep and hypnosis: the subject might describe the experience as sleep-like. Often, when waking from sleep or emerging from hypnosis, the person remembers little of what transpired during sleep or hypnosis. Some parallels exist in thought processes. Vivid dreams may occur in both states. Sleep and hypnosis are interchangeable; if the hypnotized subject is left alone, or if specific suggestions are given, he may pass into a natural sleep.

The sleeping subject may sometimes awake directly into a hypnotic state rather than into a normal waking

state, particularly if he has been instructed to do so before going to sleep.⁴ The precise state in which an individual exists at any given time is extremely difficult to evaluate by experimental means. The subject's own description of the experience ultimately provides the main criterion for determining his state.

In 1979 Evans⁵ reviewed techniques for exploring cognitive activity during sleep, citing studies by Pas-kewitz⁶ and Dumas.⁷ In particular, researchers noted the relationship between EEG alpha activity and physiology of hypnosis and sleep. The above studies examined alpha activity (7-13 Hz) during hypnosis and sleep. Some investigators⁸ have suggested that there is a strong correlation between increased alpha activity and hypnosis. According to Evans⁵, the paradox of alpha activity is that it is greatest in the relaxed state and disappears with drowsiness, arousal or difficult cognitive tasks. Evans⁴ has questioned the relationship between EEG activity and hypnosis, suggesting that it be examined in two ways:

1. Do the subjects who are highly susceptible to hypnosis have different waking brain wave patterns to those who are not susceptible?
2. Does hypnosis alter brain wave activity?

Some authors^{6,9} have suggested that alpha activity is probably not correlated with susceptibility to hypnosis. London, Hart and Leibovitz¹⁰ compared EEG alpha activity in subjects with varied scores of hypnotic susceptibility. Their basic assumption was that both waking and hypnotic states are varied states of consciousness. They also observed that people with both high and low susceptibility to hypnosis differ considerably in other psychological tests such as psychomotor coordination and rote memory. They suggest that hypnosis has no correlation with brain wave activity. Subjects who are easily hypnotized paradoxically suffer few sleep problems.

Plotkin¹¹ investigated the possible correlation between alpha wave activity in hypnosis and subjective experience of hypnotized subjects, but he found none. Clearly relaxation increases alpha activity and perhaps as Evans⁴ suggests, investigators have been monitoring the EEG correlates of the ability to accept the relaxation

instructions that are implicit and explicit in most hypnotic inductions. When the subject relaxes in the awake state, alpha activity rises.

Hodge¹² referred to the hypnotic contract as an initial agreement of co-operation between the hypnotherapist and the subject to provide circumstances under which new behavior would emerge, especially directed towards the treatment of a problem, such as insomnia. The alteration of the sleep pattern in insomnia is a learned experience. As such, what was learned in producing the problem can also be unlearned. Numerous suggestions can be used, such as "double binds"¹³ to enhance the subject's co-operation. The subject is given a choice of two actions, both of which have the same result, e.g. "Would you like to raise your hand now, or after I count to three?" This technique improves the learning experience. As Hilgard¹⁴ states, this is not a role-playing procedure "to please the hypnotist".

Finally, the mechanism by which a subject shifts from the hypnotic state to the sleeping state is not known. Why hypnosis provides effective sleep suggestions is also not known.

Insomnia Sleep Disorders

Insomnia sleep disorders can be divided into primary and secondary types. Primary sleep disorders have an autonomous function in the central nervous system.¹⁵ Secondary sleep disorders can result from causes such as depression, pain, anxiety, lifestyle change etc. Hypnosis seems to be most effective in dealing with problems of a secondary nature.

Reynolds¹⁵ has suggested that primary sleep disorders involving insomnia are of three types:

1. Sleep apnea syndromes
2. Nocturnal myoclonus
3. Restless legs syndrome

There are a number of important clinical sub types of sleep apnea syndromes, which can appear from infancy to old age:

1. Upper airway obstructive sleep apnea
2. Central sleep apnea
3. Mixed apnea
4. Pickwickian syndrome
5. Infant death syndrome

Nocturnal myoclonus is characterized by repetitive myoclonic movements of the legs during sleep. The

anterior tibial muscles are frequently affected, but quadriceps and iliopsoas muscles may also be involved. The electromyogram of the anterior tibial muscles shows a stereotype repetitive myoclonic discharge occurring more in the non-REM stage of the sleep cycle than in REM sleep. The interval between discharges is usually 20-40 seconds. There is little evidence in the literature that this problem is treatable by hypnosis.

Reynolds²⁰ describes restless legs syndrome as a disorder where the patient complains of numbness and tingling in leg muscles, associated with an irresistible urge to get up and walk. Most people experiencing this discomfort get it as they are trying to get to sleep. Hence, it is distinctly different from nocturnal myoclonus, and it is possible that hypnosis, particularly progressive relaxation, may be helpful.

Secondary insomnia is an integral part of another picture, not a primary problem in itself. Insomnia of this type can be:

1. a state in which the level of pain is too high, for example headache or joint pain.
2. a state in which the level of anxiety is too high, for example phobias, stress or depression.
3. a disturbed level of awareness which could emanate from internal sources such as thyrotoxicosis, drug side effect, prostatism with frequency, esophagitis, pregnancy. External sources could be too much or too little noise, jet lag, shift work, holidays or culture shock.

Therapeutic Approach Using Hypnosis

Hypnosis serves a number of purposes in dealing with insomnia. The motor function of the central nervous system is characterized by a triggering mechanism, which becomes more complex as it proceeds peripherally. Hypnosis serves to simplify it, lessening its activity. The opposite is true of the sensory side of the nervous system, in which a large amount of data is filtered to produce a smaller coded amount of sensory information. Hypnosis can increase this filter function, making the subject less aware of incoming sensory material.

1. Hypnosis focuses attention on problems that disrupt lifestyle.

2. It is relaxing and can permit sleep induction (for reasons unknown).
3. It alters the physician-patient relationship and permits new learning to occur.¹⁴
4. It allows for creative gaps to occur in which there is a shift of habit patterns. There is a resynthesis of previous patterns of behavior.¹⁶
5. Hypnosis is an integral part of stress reduction and an adjunct to other forms of psychotherapy.

The hypnotherapy approaches I prefer to use in treating insomnia are auto-hypnosis, ego strengthening, pain relief, hypnotherapeutic interviewing techniques, and autogenic training.

Basically, all hypnosis is auto-hypnosis. The subject is taught how to use hypnosis to fulfill his or her own needs. The extent of auto-hypnosis training can vary from the simple to the complex, the simplest being progressive relaxation. Various complex trance-deepening techniques can be used for subjects who are more advanced in using auto-hypnosis.

Ego strengthening is a concept in which suggestion is used to improve the image the subject has of himself. This can fall into two categories—the instructive and the permissive. British authors¹⁷ tend to instruct their patients by telling them that their situation *will* improve. Generally, the North American approach¹⁸ tends to be permissive, suggesting that things *may* change.

Pain relief is offered by producing a suggestion of anesthesia in an extremity such as the hand—a glove-like numbness that can be transferred to any part of the body by suggestion. This usually follows training in auto-hypnosis and imaging.

The hypnotic interviewing technique that seems to work in psychotherapy involves ideomotor activity—a very subtle form of body language. While interviewing patients in hypnosis, this activity can be observed. Sometimes the patient notices things which are equally subtle and which

emanate from the subconscious. They serve as feedback for problem-solving. This is known as ideosensory activity.

Autogenic training increases a person's awareness of changes that can be induced in autonomic nervous system functioning. The basic induction of hypnosis produces changes in autonomic functions such as breathing patterns and heart rate, and the patient can be made more aware of these.¹⁹

Some insomnia problems—for example, jet lag or shift work—are relatively simple and can be handled with a single session of auto-hypnosis training. Chronic depression is complex enough to demand greater skill in the use of more advanced hypnotherapeutic techniques. A behavioral approach involving exercise, reading, hot tubs, sex, hot drinks, and regular hours should be taken in correcting the insomnia and hypnosis can be used in addition. Hypnosis is most useful when there is a high level of expectation.

When insomnia is a manifestation of an acute or chronic pain state, hypnoanalgesia and ego strengthening may be helpful. Where anxiety and severely disturbed mental function are the principal problems, hypnosis is best used as an adjunct to other treatment means or maybe not at all. I have not used hypnosis in the treatment of schizophrenia.

I have found that hypnosis can be used to modify patients' drug requirements, for example analgesics and tranquilizers. Where the problem of hypnosis is due to environmental alteration, such as travel, hypnosis probably gives its greatest benefits. Under these circumstances auto-hypnosis and progressive relaxation are quite helpful. ●

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