

A HUNDRED YEARS AGO

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THE PSYCHIC FACTOR IN INSOMNIA

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THE MOST OBVIOUS and fundamental fact in connection with sleep is its spontaneity. It cannot be commanded, it can only be controlled within certain limits, and it brooks defiance to no great extent. The other side of this truth is that sleep is often wayward, always elusive when we try to seize it, and too shy to submit to examination.

Summary principles

These principles should be kept in mind when treating insomnia.

- 1 The essential character of the onset of sleep is its spontaneity
- 2 The patient's responsibility for his insomnia must be clearly demonstrated
- 3 All methods which draw the patient's attention to the insomnia are likely to defeat their own ends
- 4 Habit formation is of paramount importance
- 5 The emotional element must be eliminated
- 6 In the absence of physical factors, it is necessary to search for psychical causes, such as anxiety and defence
- 7 Drugs may be used much more freely, if the establishment of a sleep habit is kept in view
- 8 Occupation is invariably better than lying awake

The insomniac's responsibility

The insomniac's responsibility is a question of considerable importance because I almost invariably find that he considers himself the victim of a serious disease for which he deserves much pity. This is natural enough, in that his efforts to overcome it directly have always proved futile. Yet, in so far as there are no physical factors at work, he has a serious responsibility. That responsibility consists in the imperative necessity for self education during his waking hours, as opposed to the need for a special effort when the hour of sleep approaches. Physical factors apart, the insomniac has lost the control of his mental life; he has got to regain it.

How far he can do this for himself, and how far he may need help, is a matter for the physician's diagnosis in each case.

“The insomniac has to realize that he is responsible for his mental life as a whole, and that the insomnia is merely a manifestation of its disordered state”

It may be that some simple exercises in mental control will suffice, or possibly a course of hypnotic suggestion may be needed to break down some of the morbid associations that impede sleep, or, finally, it may be necessary to tap the sources of conflict - recognized or

unrecognized - that have disintegrated his mental life, and this can only be done by analysis. Be that as it may, the insomniac has to realize that he is responsible for his mental life as a whole, and that the insomnia is merely a manifestation of its disordered state.

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The value of occupation in the night

I wish to emphasize the value of occupation in the night. I never allow my insomnia patients to lie awake.

They must either ring for the nurse, or else set to work on a suitable occupation. Reading is the obvious resource, but it is not always satisfactory, either because of eye strain or on account of exciting subject-matter. A game of patience is the ideal occupation, and the devices known as jig-saw puzzles are also excellent.

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Autohypnosis

It is also my custom to teach my patients the knack of autohypnosis, and many of them find this a great help. However, they should first master the practice of this by putting themselves to sleep when they don't want particularly to go to sleep.

The rationale of this lies in the fact that 15 minutes devoted to autohypnosis after lunch or before dinner are free from the emotional elements of desire and apprehension of failure. Hence the patient is much more likely to be able to put himself to sleep at such times, and when he has practised it often enough he gains confidence, and is able to carry it out successfully even at bed-time.

The psychic factor

In all our treatment of insomnia - be it physical, environmental, pharmaceutical, or psychic - in all our treatment we must aim at minimizing the emotional significance of the condition.

Insomnia very often derives its emotional significance from factors in the patient's life, and in this connection we must bear clearly in mind that every neuropathic manifestation may be produced either by an anxiety mechanism or by a defence mechanism.

The following two case histories demonstrate both these mechanisms.

The Lady and Mademoiselle X

A lady had acute tonsillitis, and in the course of recovery suffered somewhat from insomnia. Her husband, in the hope of encouraging her to make a rapid convalescence, announced to her that he had business to do in Paris, but that he had put it off until she was fit to accompany him. He tried to inspire her with a little enthusiasm for this proposed trip, and by way of making the prospect more attractive he said, "We will ask Mademoiselle X to have us in her house, and I know you will like that." The patient continued to suffer from insomnia, which became more and more intractable, and her physicians were at a loss to explain it.

In the process of analysing this case, I discovered that several years before there had been a great intimacy between the patient and Mademoiselle X. The patient's husband – the mildest of men – had grown uneasy about it, and refused to allow the friendship to go on. In his desire to do everything to render the proposed visit to Paris attractive, he had suggested staying in the house of Mademoiselle X, although he and his wife had never alluded to her for all these years.

"I discovered that several years before there had been a great intimacy between the patient and Mademoiselle X. The patient's husband – the mildest of men – had grown uneasy about it, and refused to allow the friendship to go on"

Instead of stimulating the patient's recovery the opposite effect had been produced, because, in point of fact, the attachment had been a Lesbian one, and the whole complex was so painful that the patient shrank from the proposed awakening of the memory.

The first and most obvious step in the treatment of this case was to send the husband to transact his business in Paris, and remove the painful prospect from the patient's horizon.

The Lady and the Lord's heir

Lady Y, age 27, had been married three years and had suffered from insomnia for 18 months, ever since the birth of her daughter. The pregnancy and confinement had both been rather strenuous in character. She appeared to be an insomniac that nothing seemed to touch.

I preferred to go into the psychic mechanism of the condition. What I found was this: there had been intense disappointment because the child had been a girl and not a boy; she was terrified at the thought of going through this painful business a second time, and yet she realized that her husband must have an heir to the peerage. A famous consultant was asked how soon it would be safe for her to undertake a second pregnancy and confinement, and his reply was that there must be no thought of such a thing until she was sleeping quite well.

In short, then, this very simple little mechanism had been established, she had sub-consciously realized that so long as she slept badly she would be saved from facing the unpleasant and rather terrifying prospect of pregnancy and confinement.

I told her that she was never going to sleep satisfactorily until she had the prospect of again becoming a mother and that then, and only then, would she begin to sleep naturally.

She was very much surprised at my view, her husband was extremely indignant with me, and it was indicated that my opinion had been sought on quite a different topic.

However, while the patient and her husband refused to appreciate my advice, Nature came to the rescue, and a short time ago I had a letter from my patient, who appeared to have been mollified by the result of unexpected circumstances. She said that to her utter astonishment she had slept better during the last five months of physiological amenorrhoea than she had done for the last two years.

In short, the insomnia of this lady was a pure defence symptom, and it had been practically cured because her insomnia had no further defence value.

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PHOTO QUIZ ANSWERS

CASE 1 GARDENING TRAUMA

1A This is a typical pyogenic granuloma

1B It can usually be treated with curettage and cautery although a stitch may be required if there is a lot of bleeding. Histological examination of the lesion is advised to confirm the diagnosis

CASE 2 COMPLICATION OF INHALER USE

2A Oral thrush caused by *Candida albicans*

2B Use a topical preparation such as nystatin drops

2C Advise the patient to use a spacer device with the inhaler and rinse it after use

CASE 3 PYODERMA GANGRENOSUM

3A Pyoderma can be associated with

underlying inflammatory bowel disease, rheumatoid arthritis, chronic active hepatitis, Wegener's granulomatosis, PAPA syndrome and myeloid blood dyscrasias

3B Other neutrophilic dermatoses include: Sweet syndrome, Behçet's disease, neutrophilic dermatosis of the hands, erythema elevatum diutinum, neutrophilic eccrine hidradenitis and bowel bypass syndrome

CASE 4 LOCALISED PIGMENTATION OF THE NECK

4A Poikiloderma of Civatte

4B The exact cause is unknown but contributing factors are sun exposure, photosensitising components of cosmetics particularly perfumes, hormonal factors and fair skin

CASE 5 LINEAR RASH

5A The Koebner phenomenon

5B Other conditions in which it can occur include: psoriasis, vitiligo, molluscum contagiosum, pyoderma gangrenosum and viral warts

CASE 6 DARK LIP LUMP

6A This is a typical venous lake, a haemangioma found on the lips

6B Treatment is not usually required unless there is repeated bleeding or if the diagnosis is in doubt. An excision biopsy can then be undertaken