THE NATURE OF INSOMNIA IN THE PSYCHONEUROSES.

By R. G. GORDON, Bath.

Of all the symptoms met with in those who suffer from the psychoneuroses, one of the most troublesome, both to the patient and the physician, is that of insomnia. The long hours of wakefulness at night make more impression on the patient than any of his other symptoms, and unless relief can be brought in this respect the physician will find himself hampered at every turn.

In dealing with insomnia it is essential to get a clear idea as to what constitutes normal sleep; otherwise bad advice based on ill-conceived ideas may be given to the patient, with the result that his last state may be worse than his first. For example, it is common to hear a neurotic told to tire himself out and he will get sleep. Apart from the fact that in spite of extreme fatigue the patient often does not sleep, the person who gives this advice has not considered whether the sleep which is the result of fatigue is the same as natural sleep, or whether it is of the same benefit to the patient.

Much has been written on the subject of sleep, but no very satisfactory definition has yet been arrived at. It would seem to be the result of a withdrawal of vital energy from the higher levels of consciousness so that they no longer express themselves as conscious processes. The deeper the sleep, the more extensively is the content of what goes to make up the personality thrown out of action, so that in the deepest sleep only the vital reflexes persist, and of these we are seldom actively conscious. In lighter sleep, the intellectual, rational, and controlling levels of consciousness are in abeyance, but the innate impulses and the constellations of ideas repressed into the lower levels of consciousness find expression in the form of dreams.

How this withdrawal of energy takes place we do not know. Certain theories have been advanced, such as the theory of the retraction of the dendrites, but this sort of thing is necessarily purely speculative and therefore without much value. We can only accept the fact that there is such a withdrawal of energy from consciousness, and study the conditions under which it is brought about. It would seem permissible to recognize three distinct sets of conditions: (1) Sleep induced under the influence of drugs; (2) Sleep induced by fatigue; (3) Natural sleep.
All are agreed that the first is unsatisfactory sleep. It may be better than no sleep at all, but it is definitely the result of a poisoning of the central nervous system. The exhibition of these drugs is of course necessary; but the only healthy attitude towards them is that they are a reproach to therapeutics, and resemble in a certain measure the more primitive method of quietening the patient with a blow from a stout club.

So far as the second form of sleep is concerned, many people would say that we sleep when we are tired and because we are tired, and while this is undoubtedly true it is not the only reason or even the usual one; we must remember that fatigue may be either physical or mental. Pure physical fatigue, the result of excessive bodily exercise, undoubtedly induces sleep. Personal experience of bodily fatigue during the war has proved that to most of us. Sleep under such circumstances was not only possible but imperative, even under the most disturbing conditions. Sleep, then, follows physical fatigue, and it also follows mental fatigue. In considering mental work we have to reckon with its ideational and emotional sides. In practice these cannot be divorced, for the existence of completely feelingless thought has yet to be proved, and emotions cannot exist without ideas to which they attach themselves, although it is not necessary for these ideas to be conscious. The more highly toned with emotion a set of ideas may be, the more fatigue will be induced by its presence in consciousness. It is certainly more tiring to attend to a highly dramatic play or listen to emotional music than to add up columns of figures; and, as has been said, if too much work of this description is performed sleep will result; but this type of sleep would appear to be due also to a poisoning of the central nervous system, not by exogenous poisons, but by the endogenous products of fatigue which result from the metabolism of the cells of the nervous and muscular systems.

When we come to deal with natural sleep we must recognize that this is not the result of fatigue, but a protection against fatigue; that is, that it is not the result of harmful influences, but a biological protective reaction essential to the well-being of the individual. Boris Sidis, in his Experimental Study of Sleep, shows clearly how sleep saves the organism from fatigue, and Bruce1 has amplified his conclusions that natural sleep is induced by monotony. The latter has pointed out that the more varied the mental equipment an individual possesses—that is, the greater the intellectual capacity which he enjoys—the less sleep he takes and the less he needs. The converse of this is quite obvious, for both young children and mental deficients, whose intellectual outlook is narrow and consequently monotonous, require and take a large amount of sleep. The same seeking after monotony
is obvious in the steps which the ordinary person takes when he goes to bed. First he takes care to avoid physical distractions which might afflict him through his common sensations. This he achieves by lying in a comfortable bed, obtaining an equitable temperature by adequate covering, and a pure atmosphere by adequate ventilation. Next he avoids extraneous mental distractions which might afflict him through his special senses, more especially of sight and hearing, by excluding light and sound. Finally, he completes the monotonous restriction of his consciousness by not paying attention to any intrinsic thoughts which enter his mind. There is good reason to consider attention as the conative aspect of the libido or general vital energy, and therefore this deflection of attention from the stream of consciousness corresponds to the conception of sleep, as a withdrawal of libido from the higher levels of consciousness. It is this question of the cutting off of the attention preparatory to sleep which concerns us in dealing with the insomnia of the neurotic. Assuming that the theory of the psychogenic origin of the neuroses is correct, we may describe the condition as the outcome of a mental conflict within the personality. Such a conflict may refer to the past, present, or future, but in most cases it is associated with the memory of a particular event of extreme emotional intensity, though this event in turn may be only symbolic of a tendency which the patient recognizes in himself, but regards with distaste, and so refuses to admit even to himself that it exists in his mental make-up. The emotion involved may vary, but is always unpleasant—fear, anger, disgust, and the like, with their derivatives remorse, despair, etc. Owing to the presence of this intense unpleasant emotion, the ideas to which it is attached become insupportable to consciousness, and consequently must be got rid of or repressed. The way in which this repression is brought about throws light on the question of insomnia. At first there is an effort to banish the complex which is generally perfectly conscious in the beginning, though rarely it may be below the threshold of consciousness from the first. The patient gives his attention to keeping the offending material out of his mind. He avoids discussing it, he avoids reading anything which may remind him of it, and tries to cut it off from all other associations in his mind. This effort of attention is the first step towards the formation of a barrier which will repress the complex. The greater the intensity of emotion associated with the complex, the more dynamic will it be, and the more vigorously will it strive to express itself in consciousness. Hence the strength of the barrier, and the degree of attentive power necessary to establish it, will depend directly on the intensity of the emotion. The repression of a complex of low emotional tone, therefore, will not appreciably interfere with the attentive power of the subject, but
the repression of one of high emotional tone will seriously deplete his attentive capabilities, and that is what happens in the neurotic. As time goes on, the attentive effort becomes a habitude, and the patient ceases to be aware either of the complex or the effort, yet the effort is still being made. In this way the complex is repressed and becomes unconscious. However, if the barrier requires strong attentive effort, certain symptoms will arise.

For the purpose of this article, the symptoms of incomplete repression, such as obsessions, somnambulisms, and the like, which result from emotional or ideational parts of the complex escaping into consciousness, divorced from their proper setting, need not concern us. We are concerned rather with the symptoms arising from the imposition of the barrier, which occurs whether the repression is complete or not. In such cases we find that during waking periods the patient's power of attention is markedly deficient, for, if our theory is correct, most of the available attentive power is utilized in forming the barrier. It is when the patient tries to go to sleep, however, that this chaining up of his attention comes most into play. It was stated above that, in order to achieve normal sleep, all effort of attention must be relaxed, whether that effort is conscious or almost completely unconscious. In the case under discussion, however, this cannot be done, for, if the effort of attention is relaxed, then the complex will find expression in consciousness and disturb the monotony necessary for sleep. Besides this, the patient is automatically aware that such an event is intolerable, and is therefore unconsciously afraid to allow his vital energy to be withdrawn from the higher levels which intervene and protect him from his dreaded complex. Consequently he becomes more alert than ever, and gives his attention to any and every image which enters the field of consciousness, and, as he expresses it, the more he tries to sleep the wider awake he seems to get. As time goes on, however, fatigue ensues, and this induces the second variety of sleep mentioned above. Directly he loses consciousness, that is, directly the vital energy is withdrawn from the higher levels of consciousness, the barrier is partially but not entirely relaxed, and the complex can find expression in consciousness in the form of a dream. If this has sufficient emotional power it will burst right through the barrier, and express itself directly, as, for example, in the form of a war nightmare in which the patient actually goes through, in the dream, experiences typical of what he is so anxious to repress during his waking life. If, however, the barrier is still of sufficient relative strength to prevent this direct break through, the dream will only be able to express itself in consciousness in a disguised form. The mechanism of these disguises need not be discussed here; but the essence of them is that since the repressed material cannot express
itself as it is, it finds expression through more or less direct associations which are symbolic to the patient of the ideas which are being repressed. For example, suppose A represents a repressed idea and the associations to A are A–B–C–D–E, etc.; where the barrier is relatively weak, a direct association B or C may be expressed in consciousness as a dream image; but if the barrier is strong, then it is not until the associative chain has reached E or F that the barrier can be penetrated or circumvented, so that the dream image F, though connected with the repressed idea A, may differ from it very materially. The further the associated dream image is from the repressed idea, the less emotional intensity will it have and the less will it disturb the patient. The function of the barrier is to keep the patient asleep if possible, and in health this is successful; but when the repressed material is sufficiently strong to cause a neurosis, it usually finds conscious expression during sleep sufficiently directly to wake the patient. He then immediately reimposes the barrier, and sleep is once more denied him until a sufficient degree of fatigue ensues to make sleep imperative, and so the process goes on all through the night.

The degree to which the barrier retains its power during sleep depends, of course, upon the intensity of the underlying emotion, but also on the degree to which the attentive effort has become automatic and therefore unconscious. In such cases it would appear possible for the patient to fall asleep fairly readily at the first attempt, only to be wakened later by dreams. Then, the whole process being raised nearer the threshold of consciousness, the sequence described above is carried out, and he has great difficulty in again going to sleep.

Such, then, is the nature of the most important form of insomnia met with amongst neurotics, but we have also to recognize a simpler variety. This consists of a hysterical habit-continuation of insomnia: an auto-suggestion simply involving the idea that sleep is impossible. In such cases the patient has had a period during which he was bereft of sleep as a result of pain or other disturbances. However, after the removal of this cause he has persuaded himself that he cannot sleep, and does not succeed in inducing the requisite degree of monotony to procure natural sleep. This does not imply that sleep is normally induced by a conscious effort, though certain observers have declared that sleep is all a matter of ‘will’. It must be remembered that suggestion may prevent an automatic process just as readily as it prevents a conscious process. In this habit-insomnia the patient has no particularly disturbing dreams, and once he does go to sleep he generally sleeps soundly and well; it is simply a matter of not getting off to sleep. In this latter condition any treatment which will break the habit is successful, and in such cases
a course of some drug, cautiously administered and gradually withdrawn, is often very successful; but by far the best remedy, in my experience, is hypnosis. As a rule a suggestion of sleep given two or three times under hypnosis is sufficient, especially if this can be done in the evening, so that the patient can be hypnotized and left asleep.

In the form of insomnia due to emotional conflict, however, the matter is not so easily dealt with either by drugs or by pure suggestion. The former are seldom successful, but admittedly hypnosis is sometimes useful, though, in my experience, the result is apt to be only temporary. In any case, all that hypnosis can do is to strengthen the barrier, thus damping down the volcanic fires that smoulder underneath. As has been said, this may succeed, but blocking the crater of a volcano is of doubtful expediency, and the better course is for it to expend itself and to be finished with for good and all. This is done by reintroducing the complex to consciousness and getting the patient to face it and adapt himself to it and all that it may represent, so that it may be no longer repressed, thus doing away with the barrier and freeing the attention for more useful purposes. In almost every case the idea has been intolerable because the patient has not been able to regard it from more than one aspect. On being shown other aspects and led to look at it from other viewpoints, he finds that after all it was not such a terrible bogey as he thought. He finds that the experience may even be of use to him instead of a hindrance, or at least there is no reason why it should hang like a millstone round his neck. The methods of solving the conflict of the neurotic are not within the scope of this paper, which only seeks to show why he does not sleep; but presuming that the conflict is removed, the barrier is no longer necessary, and he can once more achieve that monotony which is essential to normal sleep, while at the same time he finds that his other symptoms disappear and his sense of well-being is restored.

REFERENCE.

1Bruce, Sleep and Sleeplessness, 1916.
THE NATURE OF INSOMNIA IN THE PSYCHONEUROSES
R. G. Gordon

J Neurol Psychopathol 1920 s1-1: 142-147
doi: 10.1136/jnnp.s1-1.2.142

Updated information and services can be found at:
http://jnnp.bmj.com/content/s1-1/2/142.citation

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/