REST in the Treatment of Persistent Psychophysiological Insomnia

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Every year between 33% and 42% of adults experience insomnia (Bixler, Kales, Soldatos, Kales, & Healy, 1979; Mellinger, Balter, & Uhlenhuth, 1985). The inability to get adequate sleep is a symptom that can be either primary or secondary in nature. Seven of nine subclasses are considered secondary. Only two are thought of as primary insomnias; that is, insomnias with no obvious underlying cause, such as a medical or psychiatric condition (Association of Sleep Disorder Centers [ASDC], 1979). The second most common insomnia to be treated is "persistent, psychophysiological insomnia" (Coleman, Roffwarg, & Kennedy et al., 1982).

Patients who suffer persistent, psychophysiological insomnia are characterized as having chronic, somatized tension-anxiety as well as negative conditioning in their normal sleep environment. The tension and anxiety are generally experienced as "restlessness, motor tension, ... automatic hyperactivity, apprehensive expectation, ruminative thoughts, hypervigilance, and excessive visual scanning" (ASDC, 1979, p. 24).

These characteristics make persistent, psychophysiological insomnia amenable to treatments that incorporate relaxation therapies. Behavioural treatments such as progressive muscle relaxation or
autogenic training disrupt the cognitive ruminations, and focus attention on sleep-inducing stimuli. Research shows that these treatments have been successful in easing the somatized tension-anxiety and in reducing the conditioned arousal associated with persistent, psychophysiological insomnia (Borkovec, 1982; Borkovec & Hennings, 1978; Nicassio & Bootzin, 1974; Van Oot, Lane, & Borkovec, 1983; Woolfolk, Carr-Kaffashan, McNulty, & Lehrer, 1976). It appears that the common element in the relaxation therapies is their ability to distract attention from the racing thoughts. Patients learn to focus on pleasant, soothing sensations and calm mental representations (Borkovec, 1982).

REST researchers are familiar with the relaxation properties associated with flotation REST. For example, floaters in research facilities experienced a significant decrease in plasma cortisol (Turner & Fine, 1983), and achieved significant decreases in blood pressure, plasma levels of aldosterone, renin, and urinary cortisol (Turner, Fine, McGrady, & Higgins, 1987). Hypertensives showed that flotation REST led to clinically significant decreases in both systolic and diastolic blood pressure.

Self-report data support the same conclusion. Floaters at a commercial facility significantly decreased their subjective feelings of stress and reported feeling calm, still, at rest, alert, and acquiescent after flotation REST (Suedfeld, Ballard, & Murphy, 1983). Normotensives, who floated multiple times and heard a guided relaxation exercise showed both subjective and objective signs of improved relaxation. They felt deeply relaxed. Their systolic and diastolic blood pressure decreased significantly more than subjects who only heard the guided relaxation tape multiple times (Jacobs, Heilbronner, & Stanley, 1984).

These REST studies demonstrate that flotation REST is effective in assisting individuals to experience deep relaxation, psychological calmness, and decreases in blood pressure and adrenal hormones. These features suggest that flotation REST might be an effective treatment for persistent, psychophysiological insomnia.

This study attempted to address the methodological shortcomings of earlier research. First, both subjective and objective sleep data were collected. Second, this study focused on long-term (rather than