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Sleep Issues and Cognitive Behavioral Therapy

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Abstract

A After experiencing traumatic stress, women are more likely than men to experience symptoms of a number of mental health issues, such as nightmares and difficulty sleeping. People with posttraumatic stress disorder (PTSD) frequently continue to struggle with sleep issues even after completing cognitive behavioral therapy. Imagery rehearsal therapy, cognitive behavioral therapy for insomnia, or a combination of these methods may help traumatized women deal with nightmares and insomnia. Traumatized women may benefit from having their nightmares alleviated through the use of proposing in conjunction with other psychotropic medications or psychotherapy.

Keywords: Stress • Trauma • Disorder • Treatment • Psychotherapy

Introduction

Insomnia, or difficulty falling asleep and staying asleep, is one of the most frequently cited signs of stress exposure. These symptoms frequently persist and may have a negative impact on trauma survivors that lasts for decades or longer. After being exposed to a traumatic event, women are more likely than men to experience the symptoms of psychiatric diseases like Posttraumatic Stress Disorder (PTSD), depression, and anxiety disorders. Insomnia and frequent trauma-related nightmares are two symptoms of some of these diseases. In the general population and after trauma exposure, women and girls are more likely than men and boys to report experiencing insomnia and nightmares. As a result, women who have experienced trauma need to have their sleep issues evaluated and treated appropriately. There aren't many therapy studies that focus on women's trauma-related sleep disruptions, despite the fact that women have particular sleep issues after trauma. The purpose of this article is to quickly summarize the findings of previous studies on sleep disorders in traumatized women. The clinical trials of psychotherapy and medication to treat sleep issues in traumatized women are the focus of the following section, which also offers recommendations for future research.

Literature Review

Traumatized women frequently suffer from nightmares and insomnia. Among the symptoms of PTSD that must be present for it to be diagnosed is intrusive recollection of the event, hyperarousal, and avoidance of reminders of the trauma. Women with PTSD frequently experience sleep disturbances. 73% of PTSD sufferers and 62% of non-sufferers in a sample of female Vietnam veterans reported difficulty falling asleep; 91% of people with PTSD and 59% of people without PTSD reported having trouble falling asleep. 6 percent of male Vietnam veterans without PTSD and 44% of those with PTSD reported difficulty falling asleep, while only 63% of those without PTSD and 91% of those with PTSD reported difficulty staying asleep. Female veterans may be more susceptible to sleep-onset insomnia than their male counterparts. Only 27% of female rape victims reported having nightmares, compared to those without PTSD. 4 weeks after the rape, particularly in people with PTSD, persistent nightmares persisted 12 weeks later. Trauma-related or PTSD-related objective sleep alterations are mild and frequently observed in measurements of sleep depth or rapid eye movement sleep, despite the fact that people of both sexes who have been traumatized report significant sleep disturbances [1].

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Discussion

The main BBT-I preliminary with a high level of female members (57%) took a gander at the impacts of a 1-meeting BBT-I variant on a little example (N=57) of PTSD-burdened fierce wrongdoing casualties. From the beginning to six weeks after treatment, the quality of their sleep significantly improved. The changes were not statistically significant, most likely due to the small sample size, despite the fact that the effect sizes of the improvements in sleep start and maintenance as measured by the sleep diary ranged from moderate to large. Trauma-related dreams have been treated with imagery rehearsal therapy (IRT), which was originally designed to treat nightmares. Controlled trials on traumatized veterans have demonstrated the effectiveness of BBT-I, but these trials only included a small percentage of women (10 percent to 15 percent). Learning about the formation and function of nightmares, encouraging the idea that recurring nightmares are habits or learned behaviors, rescripting nightmares, and practicing the more reassuring and comforting rescripted dream imagery during the day are all part of IRT, which typically consists of three sessions. Sexual assault survivors who received IRT had greater reductions in nightmare frequency, improvements in sleep quality, and fewer symptoms of post-traumatic stress disorder (PTSD) than women who were placed on a waitlist [2].

The perceived safety of the laboratory sleep environment has been suggested as a possible explanation for the discrepancy between the results of self-report surveys and laboratory polysomnography in adults who have been traumatized. 18 In accordance with this theory, the study included female victims of sexual assault, particularly PTSD sufferers. In the home, people with PTSD reported poorer subjective sleep quality than the other groups, but this difference between the groups was not found in the laboratory. Also, an actigraphy study showed that women with PTSD who had been through a lot of different kinds of trauma had longer sleep onset latency and slept less well than women without PTSD. This suggests that these women might have trouble getting to and staying asleep in their own beds. It has been hypothesized that people who have been abused in sleep-related situations are more likely to have trouble sleeping because they are more likely to be vigilant in sleeping environments and to engage in safety behaviors that make it hard to sleep, like checking the locks multiple times or leaving the lights on. Women are more likely than men to experience traumatic events like sexual violence, child sexual abuse, and violence in intimate relationships, which can lead to long-term mental health issues. Doctors must take into account any connections that may exist between the trauma background and sleep-disrupting habits when developing treatment plans for women with insomnia [3].

One of the most challenging symptoms of PTSD to treat is trouble sleeping. After completing evidence-based treatments for post-traumatic stress disorder (PTSD), such as cognitive processing therapy (CPT) and extended exposure (PE), patients frequently report clinically significant persistent sleep issues. In

approximately half of the cases, 27 civilian volunteers (89 percent women) with overall PTSD remission reported residual sleeplessness following CBT. PTSD affected female sexual assault survivors in two studies. One of the most well-liked evidence-based treatments for insomnia is cognitive behavioral therapy (CBT-I). CBT-I is a multimodal treatment that typically consists of six to eight sessions of sleep hygiene instruction, sleep restriction, stimuli control, sleep compression, relaxation, and cognitive therapy. Stimulus control eliminates conditioned arousal in the bed and bedroom by weakening connections between the bed and bedroom and wakefulness and strengthening connections between the bed and sleep. In order to help patients relax and fall asleep in bed, they are given instructions to stay awake throughout the night. The primary objective of the cognitive therapy module is to cognitively restructure problematic, enduring sleep beliefs [4].

Two approaches are frequently combined during the cognitive reorganization process. Identifying and implementing cognitive and/or behavioral measures to suppress dysfunctional sleep-related thoughts is one approach known as "thought-stopping." The second strategy, also known as "challenging automatic ideas," involves replacing undesirable automatic thoughts with alternative ones. A dysfunctional belief about sleep, like "Insomnia is damaging my capacity to enjoy life and prevents me from accomplishing what I want," may increase presleep distress and arousal and disrupt sleep by increasing presleep distress and arousal. Although CBT-I's efficacy in patients with insomnia and comorbid PTSD has also been investigated, few of these studies included a significant number of female participants. Two CBT-I RCTs have been conducted with PTSD patients, with approximately 70% female participants. In one of Wagley and colleagues' RCTs, significant treatment effects on sleep outcomes were only found in the study of within-subject changes and not in the study of differences between groups. In a variety of insomnia patients, including those with trauma-related insomnia, the effectiveness of brief behavioural therapy for insomnia (BBT-I), a recently developed treatment that consists solely of behavioral modules from CBT-I and lasts from one to four sessions, has been demonstrated [5].

Conclusion

Sleep issues are one of the most common and persistent symptoms of PTSD. However, only a small number of pharmaceutical or psychological clinical trials have focused on sleep disorders in traumatized women. The first-line pharmacologic treatment for PTSD, SSRIs, has not been sufficiently demonstrated to be effective in treating trauma-related sleep disruption. Prazosin has the strongest evidence of reducing the signs and symptoms of nightmares and insomnia in trauma patients when compared to other pharmacologic treatments. The importance of getting enough sleep for mental and physical health is becoming increasingly clear. Therefore, effectively treating sleep disorders following trauma is essential for alleviating the suffering caused by sleep problems and improving the health and quality of life of traumatized women. After a traumatic event, women are more likely than men to experience psychiatric illness symptoms like insomnia and frequent nightmares.

Acknowledgement

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Conflict of Interest

None.

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