

Traumatic Stress's Impact on Sleep and Women's Naturopathic Remedies

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Abstract

Women are more likely than men to experience symptoms of several psychiatric problems, such as nightmares and sleeplessness, after experiencing traumatic stress. After finishing cognitive behavioural therapy for posttraumatic stress disorder (PTSD), people with the disease frequently continue to have sleep problems. Women who have experienced trauma may benefit from imagery rehearsal therapy, cognitive behavioural therapy for insomnia, or a combination of these approaches to manage their sleeplessness and nightmares. The use of proposing in combination with other psychotropic drugs or psychotherapy may be an effective way to help traumatised women with their nightmares.

Keywords: Stress • Trauma • Disorder • Treatment

Description

One of the most often reported symptoms following exposure to stress are insomnia, including difficulty sleeping and staying asleep. These symptoms are frequently enduring and may have a long-lasting, even decades-long, negative impact on trauma survivors. Women are more likely than men to experience the symptoms of psychiatric diseases such as Posttraumatic Stress Disorder (PTSD), depression, and anxiety disorders after exposure to a traumatic event. Some of these diseases have symptoms including insomnia and frequent nightmares involving trauma. Insomnia and nightmares are more frequently reported by women and adolescent girls than by men and boys both in the general population and following exposure to trauma. As a result, it is crucial that women are appropriately evaluated and treated for sleep difficulties following trauma.

Although women experience particular sleep difficulties following trauma, there are few therapy studies that specifically address women's trauma-related sleep disruptions. This article's objective is to provide a quick assessment of research results regarding sleep disorders in women who have experienced trauma [1]. The following section of this article focuses on clinical trials of psychotherapy and medication to treat sleep-related problems in women who have experienced trauma and makes suggestions for future research.

Literature Review

Sleeps changes in trauma-exposed women

Women who have experienced trauma frequently experience nightmares or insomnia. Women with PTSD often experience sleep disturbances, and among the symptoms of PTSD that must be present for it to be diagnosed are intrusive recollections of the event, hyperarousal, and avoidance of reminders of the trauma. In a sample of female Vietnam veterans, 73 percent of PTSD

sufferers and 62 percent of non-sufferers reported having problems falling asleep; 91 percent of PTSD sufferers and 59 percent of non-sufferers reported having trouble staying asleep. In male Vietnam veterans, 6 percent of those without PTSD and 44% of those with PTSD reported having problems falling asleep, whereas 91 percent of those with PTSD and only 63 percent of those without PTSD reported having trouble staying asleep.

Compared to their male counterparts, female veterans may be more susceptible to sleep-onset insomnia. In comparison to individuals without PTSD, just 27% of female rape victims reported having nightmares. 4 weeks after the rape, and persistent nightmares persisted 12 weeks after the rape, especially in PTSD individuals. Although trauma-exposed people of both sexes report considerable sleep disturbances, trauma-related or PTSD-related objective sleep alterations are mild and frequently seen in measurements of sleep depth or rapid eye movement sleep [2].

The disparity between laboratory polysomnography and self-report survey results in trauma-exposed adults has been attributed to the perceived safety of the laboratory sleep environment as a possible explanation. In line with this theory, the study included female sexual assault survivors, particularly those who had PTSD. In the home, those with PTSD reported lower subjective sleep quality than the other groups, but the laboratory did not reveal this group difference. Additionally, a study using actigraphy found that women with PTSD who had experienced many types of trauma had longer sleep onset latency and less efficient sleep compared to women without PTSD, suggesting that these women may have trouble starting and maintaining sleep in their own beds.

It has been hypothesised that those who have experienced trauma in sleep-related circumstances are more prone to sleep disturbances because they are more likely to exhibit increased vigilance in sleeping environments and engage in safety behaviours that interfere with sleep, like repeatedly checking locks or leaving lights on. Women are more likely than men to be exposed to traumatic events, such as sexual violence, child sexual abuse, and intimate relationship violence, which raise the chance of developing long-lasting psychiatric problems. When developing treatment plans for women with insomnia, doctors must consider any connections between the trauma backdrop and sleep-disrupting habits.

Discussion

Sleep issues have been regarded as one of PTSD's most difficult symptoms to treat. Patients frequently report clinically significant persistent sleep difficulties after completing cognitive behavioural therapies (CBTs), including cognitive processing therapy (CPT) and extended exposure (PE), which are evidence-based treatments for PTSD. Following CBT for PTSD, 27

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civilian volunteers (89 percent women) with overall remission of PTSD reported residual sleeplessness in about half of the cases. In two studies, PTSD affected female sexual assault survivors. CBT for insomnia is one of the most popular evidence-based treatments for the condition (CBT-I). CBT-I is a multimodal therapy that typically entails sleep hygiene instruction, sleep restriction, stimuli control, sleep compression, relaxation, and cognitive therapy over the course of 6 to 8 sessions [3-5].

Strategies for cognitive behaviour

By destroying linkages between a person's bed/bedroom and wakefulness and bolstering associations between the bed/bedroom and sleep, stimulus control eliminates a conditioned arousal in the bed and bedroom. Patients are given instructions to maintain awake throughout the night in order to encourage the ability to unwind and fall asleep in bed.

The cognitive therapy module's main goal is to cognitively restructure problematic, persistent sleep beliefs. The process of cognitive reorganisation frequently combines two methods. One method, known as "thought-stopping," is identifying the presence of dysfunctional sleep-related thoughts and putting cognitive and/or behavioural measures into practise to suppress the thought. The second method, sometimes known as "challenging automatic ideas," entails creating substitute thoughts for undesirable automatic ones [6,7]. For instance, a dysfunctional belief about sleep, such as "Insomnia is damaging my capacity to enjoy life and prevents me from accomplishing what I want," may raise presleep distress and arousal and interfere with sleep by increasing presleep distress and arousal.

A substantial body of research backs the effectiveness of CBT-I. Five CBT-I individual modules-stimulus control therapy, relaxation, paradoxical intention, sleep restriction, and cognitive-behavioral therapy-met the criteria for scientifically supported therapies for insomnia in the review of 37 psychological investigations by Morin and colleagues. The most recent meta-analysis of 14 randomised controlled trials (RCTs) of CBT-I for primary insomnia found medium to large mean effect sizes for impacts on sleep initiation and maintenance indices between treatment and control groups (0.24-1.09) and within-subject effects (0.67-1.09).

Although people with comorbid PTSD and insomnia have also been researched for the efficacy of CBT-I, only few of these studies had a sizable female participant population. With people with PTSD, two RCTs of CBT-I have been carried out, with roughly 70% of the participants being female. Only the examination of within-subject changes, not the study of differences between groups, indicated significant treatment effects on sleep outcomes in one of the RCTs carried out by Wagley and colleagues. The effectiveness of brief behavioural therapy for insomnia (BBT-I), a recently created 1- to 4-session treatment consisting simply of behavioural modules of CBT-I, has been proven in a variety of insomnia patients, including those with insomnia associated to trauma. The only BBT-I trial with a high percentage of female participants (57%) looked at the effects of a 1-session BBT-I version on a small sample (N=57) of PTSD-afflicted violent crime victims [8].

Sleep quality considerably increased from the baseline to six weeks after treatment. Despite the fact that the improvements in sleep start and maintenance as measured by the sleep diary had effect sizes ranging from moderate to large, the changes were not statistically significant, most likely due to the small sample size. Controlled trials on traumatised veterans have demonstrated the effectiveness of BBT-I, however these trials only involved a limited percentage of women (10%-15%). Trauma-related dreams have been treated using imagery rehearsal therapy (IRT), which was originally intended to treat nightmares. IRT typically lasts three sessions and entails learning about how nightmares form and function, encouraging the perspective of recurring nightmares as habits or learned behaviours, rescripting nightmares, and practising the more reassuring and comforting rescripted dream imagery during the day. When compared to women on a waitlist, sexual assault survivors who got IRT experienced higher decreases in nightmare frequency, improvements in sleep quality, and a reduction in PTSD symptoms.

IRT has also been used in conjunction with CBT-I strategies. A 10-hour group therapy using IRT approaches and CBT-I modules, such as

sleep hygiene, stimulus control, and sleep restriction, was completed by 62 participants in a sample of victims of violent crimes who were mostly female (84 percent). Participants showed improvements in nightmare frequency, sleep quality, and insomnia from pretreatment to posttreatment. IRT was condensed and presented as a dream rescripting approach in conjunction with CBT-I in a study of 22 veterans with PTSD (32% female). In comparison to standard care, this combined intervention produced a larger improvement in nightmares, sleeplessness, and PTSD symptoms. These findings imply that IRT combined with more conventional CBT-I approaches may provide relief from trauma-related nightmares, but more studies are required to evaluate whether IRT and CBT-I combined is more efficient than IRT alone [9].

Pharmacological methods

Sleep issues have been regarded as one of PTSD's most difficult symptoms to treat. Patients frequently report clinically significant persistent sleep difficulties after completing cognitive behavioural therapies (CBTs), including cognitive processing therapy (CPT) and extended exposure (PE), which are evidence-based treatments for PTSD. Following CBT for PTSD, 27 civilian volunteers (89 percent women) with overall remission of PTSD reported residual sleeplessness in about half of the cases [10].

Both sleep quality and insomnia symptoms improved following CPT or PE in two investigations of female sexual assault survivors with PTSD, but total subjective sleep disturbance persisted after therapy at clinical levels [11]. CBT for insomnia is one of the most popular evidence-based treatments for the condition (CBT-I). CBT-I is a multimodal therapy that typically entails sleep hygiene instruction, sleep restriction, stimuli control, sleep compression, relaxation, and cognitive therapy over the course of 6 to 8 sessions.

Physical therapy with medication

Drug-assisted psychotherapy is now becoming more popular as a way to improve the therapeutic effects of psychotherapy for PTSD. The results of this strategy on sleep complaints in a sample that included women were reported by only 1 study, according to the authors. It has been proposed that D-cycloserine, a partial agonist at the N-methyl-D-aspartate receptor, will enhance the effects of exposure therapy by improving extinction learning [12]. 65 D-cycloserine was given 90 minutes before each exposure therapy session in the double-blind RCT of 9/11 attack survivors (N 5 25, 24 percent female), and participants reported less severe insomnia at 6-month follow-up compared to placebo.

Conclusion

One of the most prevalent and refractory symptoms of PTSD is sleep problems. However, only a tiny number of psychological or pharmaceutical clinical trials have concentrated on sleep disorders in women who have experienced trauma. The effectiveness of SSRIs, the first-line pharmacologic treatment for PTSD, in treating trauma-related sleep disruption has not been sufficiently established. When compared to other pharmacologic treatments, prazosin offers the best evidence for reducing the symptoms of nightmares and insomnia in those who have experienced trauma. More and more people are realising how important sleep is for maintaining both physical and mental health. Therefore, effectively treating sleep disorders following trauma is crucial for increasing the health and quality of life of women who have been exposed to trauma as well as for relieving the suffering brought on by sleep problems. Women are more prone than men to have psychiatric illness symptoms after a traumatic event, such as insomnia and frequent nightmares.

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Conflicts of interest

The authors declare that they have no competing interests.

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