

Paradoxical Intention Therapy

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PROTOCOL NAME

Paradoxical Intention (PI) therapy.

GROSS INDICATION

Paradoxical intention is thought to be ideal for insomnia disorder, particularly where there is intense preoccupation about sleep, sleep loss, and its consequences. The psychophysiological insomnia phenotype, as characterized in ICSD-2, couples sleep preoccupation with the notion of “striving” to sleep, and the maladaptive relationship between effort to sleep and ability to sleep [1].

SPECIFIC INDICATION

There is no evidence to suggest that Paradoxical Intention (PI) therapy is differentially effective in the sleep onset and sleep maintenance insomnia subtypes. The rationale for PI therapy, however, seems particularly appropriate for the psychophysiological insomnia phenotype (as stated above). There are two studies that suggest that reduction of sleep-related anxiety and performance effort may be the mechanism by which PI has its effect [2,3], but there are no formal clinical trials that demonstrate greater efficacy of PI in those insomnia patients who exhibit greater sleep effort.

CONTRAINDICATIONS

Two related notes of caution when considering PI therapy. First, PI is not suitable for patients who adopt a very concrete approach [4], or who are cognitively impaired. PI instructions (such as “remain awake for as long as possible”) are not literal commands to be implemented in an unthinking, mechanistic way. Rather, PI presents a cognitively challenging perspective on insomnia. It is important that patients understand that PI is a vehicle for a change in outlook as well as a change in behavior. Second, whereas aspects of

PI are incorporated in all elements of CBT for insomnia (see Table 6.2, later), the particular use of PI, and certainly its use as a single insomnia therapy, may require a high level of therapist skill. In these circumstances, it should be regarded as a more advanced form of sleep psychotherapy [5].

RATIONALE FOR INTERVENTION

The guiding rationale is that because sleep is essentially an involuntary physiological process, attempts to place it under voluntary control are likely to make matters worse. PI is thought to work by reducing performance anxiety (the poor sleeper's inability to produce the criterion performance for good sleep) and by reducing associated sleep worry and sleep preoccupation.

Paradoxical techniques in psychotherapy have been described for a long time – for example, 100 years ago, methods were described of treating impotence through the simultaneous prescription of intimate physical contact and the prohibition of sexual intercourse. Further work in the 1960s and 1970s developed this into a treatment program for sexual dysfunction, to good effect. Psycho-physiological relationships seem particularly relevant to PI. People have sexual responses when they try not to; people blush when they try not to blush; people stammer when they try to prevent stammering; ... and people remain awake when they try to get to sleep. The paradoxical nature of early behavior therapy treatments is also worth noting – for example, “negative practice” to break undesirable habits, “massed practice” for motor tics, “flooding” for fears and phobias (see Seltzer [6] or Espie [5] for review).

The use of PI for insomnia was adapted from Viktor Frankl's (1955 onwards) work [7] by Michael Ascher and others in the late 1970s [8,9], when it was observed that people with insomnia had more success falling asleep when they tried to remain awake than they had when they tried to fall asleep. Contemporary understanding of PI fits with the Psychobiological Inhibition/Attention–Intention–Effort model [10,11], where mental and behavioral focus on the sleep process is regarded as inhibitory to sleep engagement.

STEP BY STEP DESCRIPTION OF PROCEDURES

The following elements of PI therapy should be regarded as sequential but, for the purposes of tailoring therapy for an individual patient, they may be taken out of order, and some elements may be regarded as more or less important to include.

Consider Sleep “Normalcy”

A good starting point is to consider, with your patient, “How does a good sleeper do it?” It must be a difficult thing to be a good sleeper, or so people with insomnia might think. They usually have spent months, more likely years, trying to find a solution to their problem; to find a key that will unlock their

sleep. But here there is a special secret. Good sleepers are good sleepers precisely because what they do is second nature to them. They just don't really think about it, nor do they "do" anything in particular.

Consider that good sleepers may not even be the best at following good routines. Maybe some of them are neglectful of so-called "sleep hygiene". The point is that the good sleeper is different from the person with insomnia because whatever it is that they do is not done deliberately or anxiously with the purpose of influencing sleep. They are not preoccupied about sleep ... and so they sleep. If they don't sleep so well, then because they are not preoccupied about that it tends to sort itself out again.

Consider the purpose of "sleep hygiene"; you might even venture the idea that most good sleepers don't deserve to sleep well because they pay so little attention to it! This introduces a helpful component of the PI approach: the use of humor, which, in skilled therapeutic hands, is a very effective, and perhaps ultimate, de-catastrophizing agent [5].

Measure Sleep Normalcy

Ask your patient to complete a sleep effort scale [12], in the manner they think that a good sleeper might complete it. There is one such scale in Figure 6.1.

The following seven statements relate to your night-time sleep pattern *in the past week*. Please indicate by circling *one* response how true each statement is for you (score 2, 1 or 0 for each statement)

1.	I put too much effort into sleeping when it should come naturally	Very much	To some extent	Not at all
2.	I feel I should be able to control my sleep	Very much	To some extent	Not at all
3.	I put off going to bed at night for fear of not being able to sleep	Very much	To some extent	Not at all
4.	I worry about not sleeping if I cannot sleep	Very much	To some extent	Not at all
5.	I am no good at sleeping	Very much	To some extent	Not at all
6.	I get anxious about sleeping before I go to bed	Very much	To some extent	Not at all
7.	I worry about the consequences of not sleeping	Very much	To some extent	Not at all

FIGURE 6.1 The Glasgow Sleep Effort Scale. (Broomfield & Espie)

Each item reflects a common concern or preoccupation for people with insomnia. Their task, though, is to fill out the scale from the perspective of a good sleeper. Hopefully, they will see that the good sleeper's score would be zero, or pretty close to zero.

Develop a Formulation of Insomnia as a Sleep Effort Syndrome

By the time we see the majority of people with insomnia at a clinic, they may have spent years trying and trying to find a solution. PI offers a potential exit from that vicious cycle – by giving up trying. So, the next therapeutic task is to consider whether the patient would share a collaborative formulation that sees insomnia as a psychophysiological “sleep effort syndrome” [13].

Having considered what the “sleep psychology” of the good sleeper is like, you could now ask the patient to complete the Glasgow Sleep Effort Scale from his or her own perspective. Commonly, patients will endorse putting a lot of effort into trying to sleep, wishing they could control it, the build up of fear as bedtime approaches, excessive worry and anxiety about sleep and its consequences, and an overall feeling that they are just no good at sleep. In short, they may begin to realize that they see sleep as a “doing thing”, and that this is counter-productive.

It can be helpful to get people to understand that they should “draw the thin line” (Figure 6.2) [14]. Here is the challenge of this exercise. On the one side, there should be recognition that they need to put 100 percent commitment into putting good advice into practice, but on the other that it is crucial they stop trying so hard. Motivation and commitment are good; effort and preoccupation are bad. You should work alongside individuals toward a steady, calm, assured approach as the best way to go. The emphasis should be upon determination and not giving up, but if they cross the line from productive commitment to unproductive effort, then they will be focussing their efforts again too much

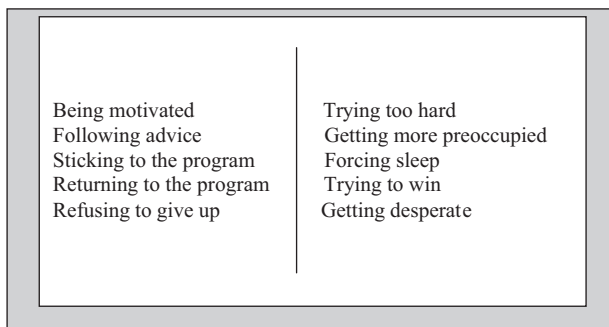


FIGURE 6.2 The thin line between commitment and unproductive effort. (From Espie, 2006)

upon trying to sleep, trying to defeat insomnia. They will lose that battle. Help patients to consider that the good sleeper is no conquering hero. They have to abandon their attempts to drive insomnia from their bedroom door, and instead to start permitting sleep to come to them in its own way and in its own time.

Draw Helpful Parallels

PI therapy requires an attitudinal shift: just as it is helpful to consider the perspective of the normal sleeper, and to contrast that with the insomnia perspective, it can be helpful to draw parallels with other problems and with other situations.

For example, a paradox sometimes occurs when people with insomnia actually sleep better when they come into a sleep lab than they do at home. This may be because they are relaxed about whether or not they sleep well; they may even want their sleep problem to be evident to others. When they have this different outlook, their sleep may actually be more normal. Another illustration that most people understand is that normal sleepers, who do occasionally have bad nights, are familiar with the experience of wakeful periods spent wishing that morning would come quickly. When finally it is close to morning, they feel relieved about it and think “well, at least I can get up now”; upon which they promptly fall asleep, being no longer concerned and no longer trying to sleep.

Moreover, in a general sense, tapping into what people already know and so what they believe to be true, can be very helpful in therapy. The laudable sporting failure is a good example(!), where the commendable desire to achieve something becomes counter-productive and impairs performance. Get people to generate their own examples. That will help them get the point – trying not to scratch something that is itchy, trying to get that tune out of your head, the audition performance that didn’t go as well as it might have, thinking too hard about your golf swing, trying to thread a needle, etc. Whether these are simple motor activities, social, sporting, or interpersonal goals, the point is that too much can spoil.

Another technique you can use for this part of the therapy is the “try not to think of a white bear” experiment, commonly used in social psychology. This demonstrates that active attempts to suppress (thoughts of a white bear) actually cause an increased frequency of such thoughts returning. There are a number of thought suppression strategies and games on the Internet which people can try. They all illustrate the importance of ironic (paradoxical) control processes.

Give Up Trying to Sleep

So what advice would PI therapy specifically offer for sleep-related behavior? Table 6.1 describes two methods for implementing PI therapy in bed.

TABLE 6.1 Methods for Giving Up Trying to Sleep (from Espie, 2006)

Method 1	Method 2
<ul style="list-style-type: none"> • Turn the tables • Take every opportunity to be carefree about your insomnia • Relish opportunities to get out of bed whenever you can • Be prepared to accept you have insomnia • Try to imagine as many catastrophes as you can that will happen just because you are awake at night; see them as exaggerated and absurd • Think of wakefulness as an opportunity, not a disaster; use the time when you are up to do something useful or something you enjoy 	<ul style="list-style-type: none"> • Try to stay awake • Lie comfortably in your bed with the lights off, but keep your eyes open • Give up any effort to fall asleep • Give up any concern about still being awake • When your eyelids feel like they want to close, say to yourself gently “Just stay awake for another couple of minutes, I’ll fall asleep naturally when I’m ready” • Don’t purposefully make yourself stay awake, but if you can shift the focus off attempting to fall asleep, you will find that sleep comes naturally

Method 1 is a “giving up trying” method (after Fogle and Dyal [2]); an extension of the attitudinal shift that you will have been working on together, and parts of it come close to the notion of acceptance and mindfulness that are reported elsewhere in this book (see Chapter 14). This method has been referred to as “turning the tables” [4]. The use of humor is powerful in helping people to take a different perspective. It helps to reduce to dust the edifices of our exaggerated conclusions and emotions. Encourage people to think “what is the worst that can happen?”, BUT rather than just challenging the true likelihood of all their wild imaginings (as you would do in cognitive restructuring; see Chapter 12) try instead going with the flow, rather than against it, by posing less resistance. Consider the scripted example in Box 6.1.

Method 1 may or may not appeal to your patient, but this more light-hearted approach could help to reduce anxiety and effort around sleep. Patients using this approach often talk about developing a completely different attitude. Indeed, the idea of accepting situations, rather than fighting them all the time has its roots in a number of ancient philosophies and religions. Acceptance leads to a problem having a less dominating position and influence. Where sleep is concerned, a more mellow perspective is an adaptive outlook, and one that can lead to improved sleep.

Method 2 is more explicitly paradoxical, where patients (paradoxically) encourage the symptoms that they don’t want to have, to keep going. The goal becomes that of staying awake, instead of getting to sleep. By deciding to stay awake, the patient is completely giving up trying to sleep. When that happens, there is a strong possibility that individuals will find themselves falling asleep, in spite of their efforts to remain awake. It can be enormously reassuring for

Box 6.1 The Use of Humor in Paradoxical Intention Therapy

Patient: It is pretty awful really when I think about it. I can't sleep at night, and then to make matters worse insomnia just ruins my day.

Therapist: What do you mean?

Patient: Well, I can't think straight, and I get irritable, and I don't get through as much work as I should.

Therapist: That's shocking.

Patient: What's shocking?

Therapist: Well, that you don't get through your work. I mean that's pretty bad.

Patient: Well it's not that I don't get my work done, it's more that ...

Therapist: Sorry, you are the one that said you didn't get through your work ... So what effect does that have?

Patient: Well, it might get noticed. I mean, my boss might notice it.

Therapist: Really! ... I guess he wouldn't like that!?

Patient: Em, no, he'd probably have something to say about it. It could affect my job.

Therapist: Wow, that's worrying. You're not getting through your work, your boss is maybe going to notice, and you might lose your job.

Patient: Yeah, it's possible.

Therapist: Have you thought about reducing your financial commitments?

Patient: What?

Therapist: ... like maybe giving up your golf club membership, or taking the kids out of private school?

Patient: No, no I haven't, but why ...?

Therapist: I mean, if these things are likely to happen then you are best to take responsible action.

Patient: I think this is maybe getting a bit exaggerated, I mean it is not that bad ... it is not even likely I think.

Therapist: Thank goodness for that! (takes out handkerchief and mops brow).

Patient: (smiles)

Therapist: (smiles, laughs): I thought I was going to have an anxiety attack there!

Patient: (laughs): Yeah, I'm like a dog with a bone about this sleep problem!

Therapist: I was just about to check if I had some loose change to give you!!

Patient: (laughs): ... very thoughtful of you.

Therapist: You know, I think you're just trying too hard in every department, ... to sleep ... and also during the day. Why don't you give yourself a break!?

Patient: (laughs): ... you're not the first person to have suggested that!

patients to find that they are overtaken by sleep. They often say things like "I don't know what happened last night. I was trying to stay awake just a few minutes longer, and the next thing I knew it was morning". This is when patients begin to realize that they can be normal sleepers.

In the Method 2 approach, people should go to bed at a normal time when they feel sleepy and put the lights off; however, their explicit intention is to

remain awake rather than to fall asleep, and therefore they are instructed to keep their eyes open and to make no effort whatsoever to sleep. This is a passive approach rather than an active one, in the sense that they should not deliberately try to keep themselves aroused. They are not given explicit direction to think about something stimulating, to move their arms and legs, or whatever, to remain awake; rather, to resist the tendency for their eyelids to close by re-opening them and keeping them open, and encouraging themselves to remain awake until sleep comes naturally. They should follow the same instructions if they waken during the night and do not quickly return to sleep. Like the good sleeper, sleep should be allowed to come to them.

POSSIBLE MODIFICATIONS AND VARIANTS

There is essentially no difference in the treatment instruction for PI when it is used for sleep onset insomnia compared with sleep maintenance insomnia or mixed type insomnia. However, there are, as we have seen, alternative ways of presenting the PI instructions.

In addition, it is important to note that there are elements of PI incorporated into almost all the proven CBT interventions for insomnia. This is illustrated in Table 6.2. The first column refers to the CBT technique itself, the second column refers to the insomnia problem that the technique is addressing, and the third column explains why the technique might be seen as paradoxical. Table 6.2 also illustrates how some of the processes in CBT (like keeping a diary) may also seem paradoxical.

PROOF OF CONCEPT/SUPPORTING DATA/EVIDENCE BASE

Paradox has been part of psychological theory and practice for a long time. Frankl's concern that patients took control of their symptoms stemmed from an existentialist philosophy [7]. His logotherapeutic approach comprised two related techniques; paradoxical intention and de-reflection. The former was concerned with increasing the frequency of responses already occurring too often; the latter involved attempting further to inhibit already infrequent responses. It is the latter response deficit which is the core of insomnia. Paradoxical intention in this sense involves "prescribing the symptom". The work of Ascher [7,8] and Seltzer [6] has been associated with the integration of PI into behavioral therapies, and there are parallels with Wegner's theories of ironic control [15,16]. PI also resonates with contemporary psychological perspectives on insomnia [10,11,17].

Treatment outcome data provide evidence for the efficacy of PI as a single therapy. Randomized, placebo controlled trials have been available for decades, demonstrating significant reductions in the principal insomnia dimensions of sleep onset latency and wakefulness after sleep onset [18,19]. In light of such data, the Standards of Practice Committee of the American Academy

TABLE 6.2 Paradoxical Aspects of Other CBT Methods

CBT method	Patient concern	Therapeutic response
Sleep Restriction Therapy	<i>I have got insomnia. I feel I am not getting enough sleep.</i>	<i>What we are going to do is to reduce the time you spend in bed so you need to stay awake for longer ...</i>
Stimulus Control	<i>I keep waking up during the night and can't get back to sleep.</i>	<i>Get up out of your bed, and get out of your bedroom, and go and read a book instead.</i>
Progressive Muscle Relaxation	<i>I feel wound up and unable to let go.</i>	<i>Tense up the muscles in your fingers and your hands to make a fist, keep the tension going at a steady rate, ...</i>
Cognitive Therapy	<i>I feel that if I don't sleep soon, then I am going to be completely useless tomorrow.</i>	<i>So what's the worst that could happen if you don't sleep? You could try that as an experiment.</i>
Keeping a Sleep Diary	<i>I just can't stop thinking about my sleep. How I sleep and how I feel the next day is constantly on my mind.</i>	<i>I would like you to start keeping a detailed and careful note of your sleep pattern and sleep quality in a diary. Now every day you need to fill this in accurately...</i>

of Sleep Medicine regards PI as an evidence-based treatment for insomnia [20,21]. Moreover, PI is often included as an element of multi-component CBT, which, like PI alone, is an effective treatment for insomnia disorder [22,23].

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