

## CAUSES AND PRESENTATION OF CHRONIC INSOMNIA AND POSSIBILITIES OF PSYCHOTHERAPY

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**Annotation:** This article describes a review of scientific literature published in recent years on chronic insomnia. Within the causes of chronic insomnia there is a special emphasis on not following sleep hygiene along with acute and constant stress. It is also mentioned about computerized technologies that are supported in terms of ensuring sleep hygiene. The possibilities of cognitive-behavioral therapy in the case of drug-free correction of chronic insomnias are widely covered in the reviews.

**Key words:** insomnia, cognitive-behavior therapy, psychotherapy.

Insomnia is a pathological condition manifested by difficulty falling asleep, frequent awakenings, and waking up exhausted without satisfaction from sleep. Insomnia is called insomnia in Latin, and agripnia in Greek. Before making a diagnosis of insomnia, it is taken into account the presence of conditions for sleep, the absence of sleep-inhibiting factors. So, if the conditions for sleep are enough, insomnia is manifested, then there is talk of a diagnosis of insomnia [7, 10].

The causes of insomnia vary, which include acute and constant stressors, lack of sleep conditions, neurological, somatic and mental disorders, night work, frequent change of place of residence, going on a trip and of course not following sleep hygiene.

Of course, subjective information has a special place in the diagnosis of insomnia. Difficulty falling asleep, frequent awakenings, incomplete awakening regardless of the duration of sleep, that is, malnutrition, are the main complaints of the patient. To diagnose insomnia, insomnia should be observed at least 3 times a week within a month [10]. Hence, the patient should almost certainly complain of chronic insomnia and this condition should last for a month. Such usually walk all day in a state of dysphoria, their attention is scattered, physical activity is slowed down and they cannot join the team.

In order to correctly determine the diagnosis, the patient's complaints, medical history and lifestyle, whether there are neurological, endocrine and somatic diseases, eating patterns, the medications he is taking, especially psychostimulants, are studied in detail [7-10]. In combination with somatic status, neurological examinations are also carried out during objective examinations. Especially the state of the central nervous system should be studied. It is necessary that the patient under observation has a "sleep diary". And this is necessary for the development of "sleep hygiene". Various psychological scales are also used in the study of insomnia. Among these, the Epworth and Pittsburgh scales occupy a special place. The state of daytime sleepiness is studied using the Epworth scale, and sleep quality is studied using the Pittsburgh scale [3, 4]. There are also questionnaires that study and evaluate the types of insomnia, with which it is also possible to study cases related to sleep quality online.

The periods of presomnia, intrasomnia and postsomnia of insomnia are distinguished. Cases that are manifested by difficulty falling asleep include presomic disorders, situations that manifest during sleep, that is, frequent waking up and lying down unable to fall asleep again, intrasomic disorders, situations that are manifested by a feeling of insatiability to sleep, apathy, general fatigue, which are observed after waking up, are called postsomic disorders [10].

In the case of insomnia that lasts more than three months, there is talk of chronic insomnia. If psychoemotional stress, anxious-phobic disorders, depression or chronic headaches continue to occur after a generally acute-occurring insomniation, insomnia also progresses to a chronic stage. It is not always possible to determine whether insomnia has developed on the basis of psychoemotional disorders or vice versa. In most cases, insomnia develops on the basis of acute psychoemotional stress, and this condition is covered in the scientific literature [1-5]. Based on statistics related to insomnia, we can say that 15% of insomnia is primary, that is, it has developed without any other cause [10].

The debate continues as to whether cognitive impairments are observed in chronic insomnia or whether there is no connection between them [1, 3, 8, 9]. Chronic persistent insomnia negatively affects the integrative activity of the brain. As a result of this, cognitive functions begin to be impaired. Initially, attention disorder develops, later memory impairment and numbness of thoughts. Of course cognitive function disorders also accelerate psychoemotional disorders. Thanks to this, it becomes even more difficult for the patient to get out of chronic insomniac.

Especially if those who are engaged in mental activity develop cognitive function disorders due to chronic insomnia, this will certainly negatively affect his productivity, and the quality of life will decrease [9, 10]. Today, among people of different professions, it is noted that among those who suffer from chronic insomnia, cognitive disorders are most common precisely among representatives of intellectual labor. Taking into account the relationship between cognitive functions and sleep disorders, it is necessary to point out the negative consequences of chronic insomnia on society and quality of life. However, there are many types of labor in which it is necessary to constantly maintain the speed and stagnation of attention.

In chronic insomnia, the scientific views on which methods of treatment are carried out vary. There are both supporters of pharmacotherapy and supporters of psychotherapy, in particular cognitive-behavior therapy and hypnotherapy [1, 2, 4, 7-10]. The views on which period to recommend sleeping pills are also different: in most cases there are many recommendations for solving this issue not directly using sleeping pills, but using antidepressants with sedative properties [2-5].

Before conducting pharmacotherapy or psychotherapy, it will be necessary to identify the causes of chronic insomnia, study the concomitant diseases and previously carried out treatment and prevention methods. Most experts believe that psychosocial factors occupy a leading position within the causes of the development of chronic insomnia [6-10]. There are also chronic neurological and somatic diseases in the elimination of chronic insomniac, non-observance of sleep hygiene, change of residence and meteorological factors are also studied.

KBT is widely supported in insomnia. Currently, there are data on the use of KBT in chronic insomniac of various etiologies [2, 7-10]. Psychotherapeutic treatment in insomnia will be aimed at improving the qualitative and quantitative aspects of sleep. To do this, of course, it is necessary to eliminate daytime and nighttime anxiety, to accelerate daytime physical activity.

In chronic insomnia, it has been shown that the effectiveness of KBT is superior to pharmacotherapy, and the results obtained are maintained for a long time [7-9]. Getting used to sleeping pills, increasing the dose over time, and considering the side effects of these drugs, indicates the need to place high hopes on KBT in chronic insomnia [5, 7, 10]. With the help of KBT, not only the normal state of sleep is restored, but in parallel, concomitant psychoemotional disorders are also eliminated [9].

Some authors suggest that it is necessary to carry out KBT and pharmacotherapy together, abandon pharmacological drugs and continue psychotherapy itself when the initial results are obtained [5]. If sleeping pills work immediately, the result of KBT will be noticeable later, and in combination with sleep recovery, it is also effective in relieving anxiety, depression and psychogenic pain [4, 6-10].

As you know, KBT consists of several components. These are sleep delimitation, sleep hygiene, sleep stimulus control, relaxation and cognitive therapy. Increased sleep efficiency is achieved through the use of KBT. There is a formula for calculating sleep efficiency:  $\text{Sleep efficiency} = \text{sleep time} / \text{time observed in the body} \times 100\%$ . Sleep efficiency is considered high if this indicator exceeds 85 % [7, 8].

In those who suffer from chronic insomnia with the help of KBT, even the correction of anxious-phobic disorders makes it possible to stretch the duration of the night's sleep [2]. In 1977, a program on "sleep hygiene" was developed [2, 7]. After the development of computer technologies, special computerized technologies were developed to ensure and study sleep hygiene in 2010-2014. An analysis of the literature showed that failure to comply with sleep hygiene requirements in 84% patients with chronic insomnia caused the development of insomnia [2, 10].

When performing relaxation during KBT therapy, it is necessary to relax the muscles of the body and make a great emphasis on light physical exercise [2, 6]. In patients with constant stress and chronic insomnia, the method of physical relaxation has been shown to reduce obsessions, anxiety and phobias and increase the effectiveness of psychotherapy [7-10].

In chronic insomnia, there will be many people who have developed "sleep syndrome", focusing their attention on sleep recovery, abandoning psychotherapeutic conversations after 3-4 sessions in cases where cognitive techniques are aimed precisely at restoring sleep. Anxiety-phobic disorders in cases where depression, parosomias and memory disorders are manifested, the effectiveness of KBT is low. They may have a need to initially use pharmacotherapy.

The programs of psychodiagnostics and psychotherapy, which are contained in the standard for the diagnosis of psychoemotional disorders, are widely used in the practice of a medical psychologist on changing patient psychology.

## Conclusions

1. The results of medical and psychological examinations, surveys from patients and instrumental examinations show that one of the first reasons for chronic insomnias is the different levels of stress experienced throughout life, and insomnia manifests itself in the form of a secondary disease in 85% of cases. So the main pathologies that cause insomnia are these – somatic disorders, depression, anxious-phobic and obsessive-compulsive disorders are severe mental and neurological disorders.
2. Not only pharmacotherapy, but also Cognitive-Behavior Therapy is effective to the golden standard of treatment of chronic insomnias, with the help of which a long-term result can be achieved. Although sleeping pills call physical and psychological dependence, the side effects are high and constant intake is impossible. Even after discontinuation of sleeping pills, the stresses that occur can put the patient back in his previous state of sleep. With this in mind, the use of psychotherapy methods for chronic insomnia is the same deadline.
3. Currently, it is proved from the methods of psychotherapy that the therapeutic effect of KBT and hypnotherapy in chronic insomnias is very high. The primary effect of hypnotherapy is to relax the patient's body, muscles and transform fears that lead to insomnia in the subconscious, while KBT consists in identifying irrational thoughts that cause chronic insomnias and rationalizing them. After both therapies, relief appears in the patient's general condition and body, and the patient becomes free from excessive unnecessary thoughts. This ensures a quiet sleep of the patient.

## References

1. Brooks SK, Webster RK, Smith LE, et al. The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the Evidence. *Lancet*. 2020 Mar 14;395(10227):912-920.
2. Edinger J.D, Sampson W.S. A primary care «friendly» cognitive behavioral insomnia therapy. *Sleep* 2003; 26:177–82.
3. Fang H., Tu S., Sheng J. Depression in sleep disturbance: a review on a bidirectional relationship, mechanisms and treatment // *J. Cell. Mol. Med*. 2019. Vol. 23, no. 1. P. 2324–2332.
4. Griffin S.C., Williams A.B. Reciprocal effects between loneliness and sleep disturbance in older Americans // *J. Aging Health*. 2019. Vol. 9, no. 2. P. 1156–1164.
5. Härtter S, Grözinger M, Weigmann H, et al. Increased bioavailability of oral melatonin after fluvoxamine coadministration. *Clin Pharmacol Ther*. 2000 Jan;67(1):1-6.
6. Härtter S, Wang X, Weigmann H, et al. Differential effects of fluvoxamine and other antidepressants on the biotransformation of melatonin. *J Clin Psychopharmacol*. 2001 Apr;21(2):167-74.
7. Ibodullayev Z.R. Tibbiyot psixologiyasi [Medical psychology] // *Darslik*, 3-nashr, 2019 y, 494 b.
8. Lauriola M., Carleton R.N., Tempesta D. A correlational analysis of the relationships among intolerance of uncertainty, anxiety sensitivity, subjective sleep quality, and insomnia symptoms // *Int. J. Environ. Res. Public Health*. 2019. Vol. 16, no. 9. P. 3–15.
9. Practice Parameters for the Psychological and Behavioral Treatment of Insomnia: An Update. An American Academy of Sleep Medicine Report. *Sleep* 2006; 29: 650–659.
10. Roth T, Roehrs T, Pies R. Bessonnica: patofiziologiya i posledstviya dlya lecheniya [Insomnia: pathophysiology and consequences for treatment]. *Sleep Med Rev*. 2007; 11 : 71–79.