Shrink Rap Radio #248, October 1, 2010. Sound Sleep, Sound Mind

Dr. David Van Nuys, aka "Dr. Dave" interviews Dr. Barry Krakow
(transcribed from www.ShrinkRapRadio.com by Jo Kelly)

Excerpt: *"Most insomniacs actually do get sleepy, but they get sleepy at the wrong time of day: often in the early evening, or in the afternoon and they will even tell you sometimes they doze off. But in the evening time they have done certain things, or certain things have taken hold in terms of their own habits, where they do not necessarily or naturally bring the wave of sleepiness in close to bedtime. And that is one of the things that we teach them: how can you bring the wave around the evening bedtime hours, so that you can tap into it and go to sleep; and if you wake up at night, tap into it again and go back to sleep."*

Introduction: That was the voice of my guest Dr. Barry Krakow, discussing the problem of insomnia and keys to sleeping through the night. Barry Krakow, MD is a board certified internist and sleep disorders specialist who has spent over 30 years in medicine in the fields of internal, emergency, addiction and sleep medicine. He has conducted more than two decades of research in the treatment of chronic nightmares and disturbing dreams at the University of New Mexico School of Medicine, and the Sleep & Human Health Institute.

Dr. Krakow graduated magna cum laude from the University of Maryland School of Medicine. He was residency trained and board certified in internal medicine and also has ten years of clinical work in emergency medicine. He is a member of the American Academy of Sleep Medicine and the Sleep Research Society and is the former medical director of University Hospital Sleep Disorders Center.

Dr. Krakow has published two books, *Insomnia Cures* and his most recent, *Sound Sleep, Sound Mind*, which is the first book of its kind to focus on mental, emotional and physical causes of sleep disturbances. Dr. Krakow and his wife, Jessica Kohr-Krakow have also published *Turning Nightmares into Dreams*, an innovative self-help audio series and workbook to eliminate bad dreams.

Dr. Krakow is the medical director of Maimonides Sleep Arts & Sciences, in Albuquerque, NM as well as the principal investigator of the Sleep and Human Health Institute, a non-profit research facility.

Also, you can find information about his upcoming workshops on his websites, which include:

www.sleeptreatment.com and www.nightmaretreatment.com

Dr. Dave: Dr. Barry Krakow, welcome to Shrink Rap Radio.

Krakow: I'm excited to be here – thanks David.

Dr. Dave: You and I have both been members and presenters at the International Association for the Study of Dreams Conferences, and I believe we met at one of those sessions a few years back.

Krakow: Right, right.

Dr. Dave: Now you trained as an internist and later worked as an emergency room physician, so how did you come to be interested in sleep?

Krakow: Well I had my own sleep problems for years, and I don't know that that actually got me into the field. I started doing some work on nightmares back in 1988 with Joseph Neidhardt and Robert Kellner at the University of New Mexico School of Medicine, but as I got more into the field of nightmare treatment and nightmare research I noticed that a lot of the things I was reading about were relevant to my own sleep problems. So I found that it was very useful to start applying techniques to treat my own insomnia, my own sleep breathing conditions – I even have a mild case of restless leg syndrome – so once those connections started to get made it turned out to be a very useful field to go into (laughing).

Dr. Dave: Yes, it sounds like it. People often speculate that psychotherapists go into (laughing) the work of psychotherapy because really they need to work on themselves. This sounds like an interesting variant on that theme.

Krakow: Absolutely.

Dr. Dave: Yes. You have your own sleep clinic now, there in Albuquerque, NM called the Maimonides Center, and you also head up your own sleep research institute, is that right?

Krakow: Right. The research institute is the Sleep and Human Health Institute – that started in 2000 – and then to actually be able to put food on my table I opened up a sleep center in 2002, which is the Maimonides Sleep Arts & Sciences.

Dr. Dave: I love that fact that you are involved both in research and in practical application, and that the two are nurturing one another.

I've been reading your 2007 book, *Sound Sleep, Sound Mind: 7 Keys to Sleeping through the Night. The Drug-Free, Mind-Body Approach to Getting the Sleep You Need*.

How big a problem is insomnia?

Krakow: It's huge. It's probably the single biggest sleep disorder out there in the sense that even though people don't use that word insomnia, what they describe fits the category of insomnia. That is a large proportion of the population will say either they have difficulty falling asleep, difficulty staying asleep, early morning awakenings, or they will say that the quality of their sleep is non-restorative. All four of those categories meet nosological criteria, you know the actual definition, diagnostic criteria for insomnia.

It's amazing how many people – maybe more than half the population – can have that problem at any one time. Obviously there's people who have it much more severely, and that is thought to be somewhere in the 11% to 17% range of adults who have chronic, and significant clinically meaningful insomnia.

Dr. Dave: Well I know from personal experience, as well as that of my wife and other close friends that it can be very frustrating. For me it's not chronic, but every now and then I'll have a run of insomnia.

Am I right that you suggest that rather than lying in bed and struggling to get to sleep, you suggest getting up and going to another room and occupying yourself until you get sleepy?

Krakow: Right. Dick Bootzin pioneered this concept called "stimulus control" – I think the data was published back in the 1970s – showing that when a person lies in bed not sleeping, they are in fact teaching themselves not to sleep. The psycho-physiological conditioning that ensues is one of the leading causes of insomnia. So the person who can break that cycle (and it's not always easy to get up out of bed at 4 o'clock in the morning and go do something else) but when a person does that, and does it the right way –

which means not with lots of stress in their mind, and not lots of worry about losing more sleep – then there is a good chance they will break that cycle. They will get sleepy again, they will go back to bed, and they will go to sleep.

Dr. Dave: It seems to me that this whole field of sleep and insomnia, in terms of advice – I've read other books and it seems maybe it's a little bit like the field of nutrition, where you get this conflicting advice about what you should be eating – don't other "experts" advocate just lying there, saying that the rest will do you good whether you actually sleep or not?

Krakow: Well I'm sure there are people who do, and I'm not trying to make fun of anybody, but it's a question of what kind of expert are they? In other words, are they actually somebody who studied the science of sleep and understand how insomnia does produce a very vexing mental state that leads to a tremendous amount of agitation, racing thoughts, ruminations? And if so, what is the model that allows them to say, "Well just stay in bed and get some rest" and so forth.

In my clinical experience there are a few cases where you may have somebody just lay in bed because that person may have a pain syndrome, or something that makes it very difficult for them to get out of bed. But long term, as much as I do advocate the use of this technique "stimulus control", the techniques I have in my book involving working with thoughts, feelings and images can eventually lead most insomnia patients to not have to get up out of bed.

I'm simply describing that method because you mentioned it, and it's a very powerful method. It can be very useful in the short term for many, many patients because it relieves the pressure. But long term I would prefer to teach people how if they woke up in the middle of the night they could actually roll over and go back to sleep within just a couple of minutes.

Dr. Dave: Yes, and I definitely want to get into that, and that's a useful clarification.

I'm wondering if there might be two different issues? The first one being difficulty falling asleep when you first go to bed, and the second one being waking up during the night and having difficulty getting back to sleep. I think they are both called insomnia, but I'm wondering do these have different underlying dynamics, or are they essentially the same issue?

Krakow: That is one of the more interesting areas of the research on insomnia, because in one sense they are the same in that the person who does wake up in the middle of the night – their real complaint isn't necessarily that they woke up, their real complaint is usually that they have trouble going back to sleep. Which means it is just like the beginning of the night, they have trouble going to sleep. So there is that particular part of it.

Now as we have spoken about previously, we have been doing research on this exact problem called, *Why Do Insomniacs Wake up at Night?* We are working on a study right now where we are looking at classic insomniacs who have no other symptoms, just the insomnia that has been bothering them – no other explanation for it – and what we have found is that most of them have a breathing event prior to their waking up in the middle of the night. In that particular case though, they still have the same problem. So regardless of the cause of why somebody wakes up, the insomnia patient tends to have this trouble of going back to sleep, and again that mirrors what may be the same problem they have in the beginning of the night. So there are some differences, but that one particular theme is there and that does tie it together and sometimes help insomniacs in their treatment because they begin to realize, "my difficulty is that I can't get to sleep".

As I describe in my book, one of the biggest reasons for that is that these individuals have difficulty recruiting what I call the wave of sleepiness that a person should be able to recruit when they are either going to sleep, or if it's the middle of the night, and they are going back to sleep.

Dr. Dave: I love that you are talking about this wave, because my wife and I have had this long standing marital joking "argument", because for years I've said, "No I've got to go to bed now, I don't want to miss my wave; I've got to catch my wave". Almost like it's surfing.

Krakow: You're from California.

Dr. Dave: Yes (laughing). But I've had this sort of intuitive sense that there is this wave, and I have to catch it, and that if I miss that wave by going to bed later than my normal time I'm going to miss that wave.

Krakow: There is some element of truth in that, in that what you'll see is there are certain patients who they go a little bit beyond their "normal bed time" and they suddenly wake up a little bit, get a little bit more alert, and the next thing you know they are into something else. So I think there is some truth in that, although again what I teach is that once you really learn what underlies the things that would block that wave, then you can actually realize

that you can make the wave come on at the "right time" is what I'll call it, in the evening at bed time, and so forth. If you happen to miss a particular night, then it doesn't take a lot of steps to bring it back, as long as you understand what that process is that was blocking the wave.

Dr. Dave: I guess I had the impression that there was some kind of 90 minute biorhythm cycle going on in the background.

Krakow: I think there are people who try to exclaim those kinds of research ideas in a way to say that that will absolutely, unequivocally tap into when you should go to sleep, and so forth. I don't think that that is necessarily true. It may be true for somebody who is really having difficulty with sleep schedules, and needs to normalize or regularize their sleep schedule. But really the wave is growing all day long, because as you continue to be awake what's called your homeostatic sleep pressure or sleep drive is building. So it's there, and that's one of the things that is so fascinating about insomnia patients.

Many, many insomnia patients – and this is usually not perceived in the conventional wisdom of science, which is unfortunate, and I have many debates with my colleagues about this – but most insomniacs actually do get sleepy, but they get sleepy at the wrong time of day. Often in the early evening or in the afternoon, and they will even tell you sometimes they doze off. But in the evening time they have done certain things, or certain things have taken hold in terms of their own habits, where they do not necessarily or naturally bring the wave of sleepiness in close to bedtime. And that is one of the things that we teach them: how can you bring the wave around the evening bedtime hours so that you can tap into it and go to sleep; and if you wake up at night, tap into it again and go back to sleep.

Dr. Dave: Well how do you bring the wave in?

Krakow: Well, the way things start here is that we think about what the classic presentation is for an insomnia patient when they come to Maimonides; and I will tell you that the individual who sees us is usually middle aged, maybe a little bit older, could be a man or a woman, and they've had the insomnia for several years. It's never like they just walked in the door because they've got three months of insomnia – in fact it's rare to meet somebody who has had insomnia for less than a year – usually these people have struggled with the problem for two to twenty years.

And what we find in the very first session, what we talk about in the very first session, and what I emphasize over and over in the sound sleep book –

is that these individuals are completely out of balance with what I call the TFI System, which stands for Thoughts, Feeling and Images. And of course feelings encompasses the feelings of sleepiness, the feelings of fatigue, but also lots of other feelings – lots of emotions that people have.

What I've learned is that most of these people are living, so to speak, in their minds. Most of their attention is spent towards the cognition of verbal thought, racing thoughts, ruminations, driving themselves very diligently during the day on their work, but also ruminating on their problems. What I'm saying here very literally is they spend much of their life in their mind, and they do not have a strong appreciation of the way their body works in terms of feelings and emotions. And the reason this is so critical is that the wave of sleepiness is tied into feelings that also are coming through the body, not just something experienced through the mind.

Dr. Dave: Yes, that's really fascinating. Now in the book you say all sleep is not the same, that there is quality sleep, and you seem to come down pretty strongly on the point that most people are not getting high quality sleep. Now how do you judge sleep quality?

Krakow: Well it's an interesting question in its own right because what it actually triggers is the concept of how people even think about their sleep. In other words, getting the quality sleep is a fairly complex process where you have to look at lots of mental and physical factors. But when I was referring earlier to the TFI System and how people are thinking about things too much in their life, as opposed to doing more feelings, what happens is they adopt a thought about sleep which is strictly geared toward how much sleep they are getting.

This is one of the first paradigms that we have to sort of break through if we are going to teach them how to get to the wave of sleepiness. We are going to have to get them to be able to see that the thought about counting up hours of sleep is actually going to cause them a problem; because what they should be feeling is an understanding about what does it mean to have quality sleep.

Quality sleep would mean that you wake up in the morning and you feel great. You have energy throughout the day. You get back into bed at the end of a long, good, strong, active, fulfilling, satisfying day and then you get back into bed and what do you do? You recruit the wave of sleepiness, and you fall asleep, and you sleep all through the night, and you feel great the next morning.

So that process is something that people who are going through this – the insomniacs – really have very little appreciation for. They all think about it as, well it's insomnia, so I must not be getting the right number of hours of sleep. And this is why we focus so much on the TFI System, because only by working on the TFI System – Thoughts, Feeling and Images – can we teach them the balance points that allow them to understand that they can do this, they can actually change their perspective, and get away from the concept of sleep quantity and then be thinking about sleep quality. It's once you do that, then you do have a chance to understand that you have control over the wave of sleepiness.

Dr. Dave: OK. Now one of the things that fascinated me in the book is your assertion that most people are not getting good quality sleep because of micro awakenings during the night. I think you suggested that some people actually might have 300 micro awakenings in a single night. Tell us about that.

Krakow: Yes. Most people with insomnia, the research shows that they are hyper aroused. But the theory about this is very confusing, because the only working theory of hyper arousal right now is that either the patient is born with it, or they are just psychologically predisposed to it because, again maybe they are a worrier, or they are tense.

This again goes back to the TFI System in terms of the feeling component, and what happens is these people are not able to organize themselves in a way on a daily basis to cope where they can actually reduce the arousal. As I've mentioned in other venues, this arousal also may be a function of these breathing disorders, but the truth is many people with insomnia, for whatever reason have multiple awakenings and arousals during the night.

In my book, *Sound Sleep* what I talk about is that you can actually trigger part of that by the way you are working with your feelings and with your emotions during the day. If you are somebody that is not coping well – and by that I mean not engaged in active emotional processing throughout the day – you are going to build up more psychic tension, more physiological tension; and that process is the one that is absolutely classic.

Going back to this concept of the classic presentation of the insomnia patients we see: not only are these individuals thinking too much, but the way they are working with their emotions during the day – which is almost non-existent in many cases – is actually now leading to a hyper arousal state, which then of course is going to carry over into their sleep.

Dr. Dave: So you are not only going to work with them around issues in the sleep lab, but you are also teaching them what, strategies for handling their emotions during the day? What would be your approach to that: would it be cognitive behavioral, or psychoanalytic, or ... ?

Krakow: Well we take a cue from Leslie Greenberg's work. He uses the term "emotion-focused therapy" and we use the term "sleep related emotion-focused therapy". I was very honoured that Dr. Greenberg put a blurb on our book, *Sound Sleep* regarding our work on sleep related emotional processing. Where we start with this, this is a typical example that comes up in the clinical encounter with the patient – usually the very first encounter – and I will ask the patient: so what exactly is going on with you that is causing you not to sleep? And most of the time people will say things like, "I think too much, I've got a lot of racing thoughts". They will say, "I'm anxious, I'm stressed; I'm anxious, depressed; I worry" – a bunch of buzz words, in my mind – they are more on the surface than what is really going on.

So I will say to them, can you give me an example of what you mean by that? In other words, when you say you are stressed out, is there some example maybe that happened yesterday, or last week? And literally in five seconds the patient will say, "Well sure, yes, at work I had such and such an encounter with my boss." And they will start talking about this encounter. What is so fascinating to listen to these people is that as they talk about this encounter, they will never once mention any emotion or feeling that occurred in the encounter.

So basically they are describing some kind of conflict, say with their boss. And I will say to them, well so that's what stressed you out? And they will say, "Yes I have that a lot with my boss; I get stressed out". I say to them, well did you feel anything else besides stress? They look at me like I'm from outer space, like what do you mean. Well did you feel something else there? Was there some other feeling, emotions, whatever? The person might take a step back, and say, "Well, as a matter of fact yes, I was somewhat frustrated." I say, good; now let me ask you this question, because this is the 64,000 dollar question – and I can say that because we are the same generation, right David?

Dr. Dave: Right (laughing).

Krakow: OK. So here is the 64,000 dollar question I will ask virtually every insomnia patient, and I will almost always get the "wrong" answer.

I will say to them, where do you feel that frustration? And of course this is a trick question, because almost every insomniac will look at me and they will go, "Well I feel it at work sometimes, and I'll feel it sometimes at home". I say, no no, what I want to know is *where* do you feel your frustration? And they still look at me; and I finally have to say *where in your body* do you feel this frustration? And the answer in 90% of the cases is, "Well I don't know what you're talking about" and they point to their head, and they say, "That's where I know it. I know it in my head. I think about it, I don't actually feel it I guess".

And this is the hallmark sign that these individuals are not really experiencing their emotions the way emotions are meant to be experienced, which is of course you are supposed to feel them in your body. This is the first breakthrough that these patients have, where they begin to realize that when I say thoughts, feelings, images I really mean it. The patients actually resonate with this very, very quickly because they go, "Oh you mean this is what's the cause of my racing thoughts?" I say, absolutely, your racing thoughts are your manifestation of how you learn to work with human emotion, and it's very ineffective, it's very inefficient, and we are going to have to teach you ways to start getting back in touch with what you can feel in your body.

The good news is there are some patients when you have this discussion they will say, "Oh I know what you mean. Like that time that I got angry six months ago, and I actually felt it in my chest, and I got really tight and red and angry." Yes that's called feeling your emotions, as opposed to thinking about them. So when that happens, that particular patient I can say, look you've already done this, you are moving in the right direction.

The goal of course of this is not emotional venting, or emotional expression in excess. It's rather understanding what the nature of human emotion is about, how it is supposed to serve you and protect you, and how it is supposed to help you by providing you with a form of emotional intelligence that allows you to move through your day in a much more relaxed fashion.

Most insomniacs do not understand this, and this is one of the main triggers to how they end up with insomnia.

Dr. Dave: So in part, what you are doing is kind of an educational process and teaching them to be sensitive to things that are currently out of their awareness, that they are handling in kind of an automatic way.

Krakow: David, let me just mention – that is exactly right, because their automatic way means "ignore the feeling, ignore the feeling, ignore the feeling; let me think about the feeling." One of the crux discussion points for these patients in their education is: do you actually understand the difference of what it means to think about a feeling, versus actually feel a feeling? Most of them will say, "No I don't think I understand that."

Dr. Dave: Yes, yes. Now speaking of things that are automatic, I want to go back to the breathing because these micro awakenings are often caused, as you mentioned earlier, by breathing problems. And you used the term SDB – which I guess stands for "sleep-disordered breathing" – and the challenge there is that we are not aware of these breathing problems that are disturbing our sleep.

Krakow: Right, and not only that but breathing problems, by causing so much fragmentation of the sleep, because remember there are three basic types of breathing events: apneas means that you stop breathing, hypopnea stands for about a 50% reduction in breathing, and something we call upper airway resistance is about a 25% reduction in breathing.

Well, it's kind of like analogous to the concept of pregnancy: can you be a little bit pregnant? Can you have a little bit of breathing difficulty? You see each of these breathing events are like mini suffocations, and it doesn't matter whether it's a 25%, a 50% or 100% all three types of breathing events do trigger arousal activity in the mind. This is what will cause hundreds of arousals during the night. Obviously it's a form of sleep fragmentation leading to sleep deprivation, because with so much sleep fragmentation you are eventually losing some of your sleep. When that happens, you get to be tired, and cranky, and irritable, and anxious and depressed the next day.

So now you have got a physiological explanation for why individuals would also have difficulty coping with their emotions, or even being aware of their emotions. They are just plain too tired to do it.

Dr. Dave: So there is kind of a vicious cycle going on there.

Krakow: Yes.

Dr. Dave: You know I think many of us have heard of sleep apnea, but it sounds like there are breathing events that maybe wouldn't reach that criterion that we think of as apnea, where a person just stops breathing for a

while. That there are much less dramatic events but nevertheless they are having an impact on the quality of our sleep.

Krakow: Absolutely. That is very germane to insomnia patients, because they often will produce not the classic apnea problem, in terms of diagnosis, but these other events that I mentioned – hypopneas and upper airway resistance. Yet these 25% to 50% reductions are more than enough to produce these arousals and these awakenings. In fact as I mentioned in the study that we were looking at recently these awakenings are often caused by people having the breathing event.

But I want to go back if we might to the concept of how all of this plays out in terms of this set of breathing problems, these stressors from not dealing with your emotions. How it all conspires to again get the individual caught up in not looking at the quality of their sleep, getting totally mesmerized by the idea that the number of hours they are supposed to sleep is where the secret to their solution is here, and then how when that keeps playing out it prevents individuals from recognising how much power they have within themselves to take control of their sleep problems simply by balancing the Thoughts, Feelings, Imagery System.

When you mentioned earlier about the concept of, do you get up out of bed, or do you stay in bed – what we are learning is that when we can treat somebody's imbalanced Thought, Feelings, Imagery System, teaching them how to reduce the racing thoughts by spending more time working with their emotions, and even throwing in some imagery work, these things then will allow a patient to roll over and get back to sleep in a very reasonable fashion, and not have to take a pill. That's why this is so powerful, because it's something within the individual that they can do.

The secret to it though, as far as I can tell from my clinical work, has been that most of these patients will not address their lack of coping skill in terms of how they actually process emotion. They really just don't get it. Some of them it takes a couple of weeks, some a couple of months, some a couple of years.

But the exciting thing for us in treatment is that they don't have to become a super emotional processing people. It's not like it's a psychotherapy and it takes two years to do it. It turns out that if a person just begins to recognize this process, that their racing thoughts really are a form of trying to block themselves from feeling – just that single idea can actually begin to free up the insomniac where literally in the middle of the night they have racing thoughts – we teach them what's the very first thought you want to have

once you recognize you have racing thoughts? And the answer is, "I must be hiding from some feeling."

Now if the insomniac can do that, they will actually start to move down the direction of saying, "Well what's the feeling I'm hiding from?" And once they start to do that there is a chance they are going to feel some of that feeling, and that is enough sometimes to break the cycle of insomnia, which is amazing how little they have to do to get there.

Dr. Dave: Well that's fascinating. I'm still hung up on the breathing issue. In relation to that, what is the relationship between snoring and sleep quality? That part was a little confusing for me in the book.

Krakow: Snoring is something that is confusing, and it's something we try to get our patients away from paying much attention to, because snoring produces an outward appearance of a problem that does not reflect back on what is going on internally in the body. What I mean by that, is that you can snore and not have a sleep breathing problem, but more importantly you don't have to snore to have a sleep breathing problem.

So in research we have done with insomniacs, we have seen situations where 75% of the patients walking into clinic will say, "I don't snore." Then we put them in the sleep lab and 75% of them snore.

Dr. Dave: (laughing)

Krakow: So it's very, very confusing but again I want to point out that unfortunately the mainstream media plays on this particular problem of snoring in a way that comes to the point of what I call media malpractice. Because they will actually say in their coverage – and I see this all that time in news clips, in magazine articles, in newspaper pieces – where it says the phrase, "if you don't snore then forget about having a sleep breathing problem." That's absolute nonsense. That was disproven more than twenty years ago. There are many, many people who don't snore, who have very serious sleep breathing problems that need to be treated. Among them as you might guess from our discussion today, insomnia patients are one of the biggest categories of people who don't snore, and yet still have these sleep breathing problems.

Dr. Dave: Interesting. In your book you talk about the airway passage, the flow of air, and even advocate that people experiment with these nasal strips. As a matter of fact I started doing that again just as a result of reading the book. I have done it in the past when my nose was all plugged up, but I

think actually in my own case I don't think I have a super wide air passage, and I think that could be helpful. So I am going to see how that goes.

Krakow: We are going to have to fly you out here and get a sleep study in Albuquerque.

Dr. Dave: Well believe me, I'm thinking about it.

Krakow: This is the part that was so important for me in terms of writing the *Sound Sleep* book, because in putting forward my paradigm, what I call Sleep Dynamic Therapy, it was very clear to me that if you really want to help an insomniac you've got to look at the mental physical components, the psychological and physiological. They are both incredibly powerful.

I'm so pleased that you are seeing all the information we have there about the breathing disorders, because we know that most insomnia patients, from our clinical work – and we are talking about thousands of people that we have seen – have these sleep breathing problems. Sometimes they are mild, sometimes they are moderate, sometimes they are severe. But it's very difficult to get a great treatment for the insomnia patient unless you can help them to fix their breathing problem – by using CPAP, or dental devices, or nasal strips, or allergy treatment – whatever it takes.

But on the other side of the coin is the psychological treatment, and I will say the same thing: unless I can get them to have a little bit of a breakthrough about their emotional processing problems, I will have again a problem getting them to where I want in terms of optimizing their care. In the *Sound Sleep* book we deal with that, we deal with all of this stuff.

In our clinic we don't say to the patients what is some of the traditional models that we think are mistaken, honestly. Most people look at insomnia patients and say, well give them this cognitive behavioral therapy for several months, and if it doesn't work get a sleep test. Somebody else might say, well they are snoring so get the sleep study first and if they still have insomnia we will give them some CBT six months later.

We don't do that at all. Everything is simultaneous therapy at our center. We want the patients to get the sleep breathing evaluation right away, but we also want them to get a complete understanding and education about the TFI System – the Thoughts, Feelings, and Images – so they can see what part of that might be causing the psychological part of their insomnia.

So we go down the psychological and the physiological paths together, and I can't tell you how many people love that. They just love it, and the reason they love it is because most insomniacs think there is something physically wrong with them. It's amazing how much smarter the patients are than the clinicians, because in terms of conventional wisdom it's actually taught to ignore the patient when they make that comment. You are actually told that when the insomnia patient says there is something physically wrong, don't believe them, because it is probably likely to be psychological, or psycho physiological. The truth is, the insomnia patient has been right all along, there tend to be a lot more of these breathing disturbances in insomnia patients than anybody would have previously imagined.

One of the reasons I am so passionate about it is that I discovered it in myself about thirteen years ago, and I had the good fortune of a colleague of mine, Thomas Meade, who is a dentist and he made one of these dental devices for me. I had been having insomnia for about two years and I was waking up every night, and he said, Barry just try one of these dental devices and see what happens. And I began using a dental device and my insomnia all but disappeared.

Dr. Dave: What sort of device is this?

Krakow: These are things that go into your mouth, it's a double dental impression and it holds the jaw in a slightly thrusted position, where the lower jaw extends out a little bit more than usual, and by doing so the back of the throat becomes a little bit expanded, and you breathe better.

Dr. Dave: Now are these generally available? If somebody wanted to try it, is this something somebody could order? What would they ask their dentist for?

Krakow: Well you would have to go to the dentist and ask for oral appliance therapy, and oftentimes you would meet a dentist who doesn't know how to make one, or hasn't had experience in making one. Then you would have to find a dentist who does have the experience, because usually they are shipped out to a lab and manufactured. They are fairly expensive, oftentimes insurance coverage is available for some of them.

There used to be models sold over the counter that are called "Boil and Bite" devices; I don't know if they are even available anymore because they were very problematic. These are the kinds of things when you are working with your teeth you want to get an expert working on it, so that there is not

something that they are going to mess up your bite or cause other dental problems.

Dr. Dave: You know I am glad you raised the issue of what other clinics do. This is not the only sleep center in the country, right, there are other sleep clinics scattered around. I've wondered how controversial is your approach, because I haven't heard previously of your TFI approach where you combine emotions and so on, and also the emphasis on micro awakenings. So I am just wondering if other sleep clinics use the same paradigm, or if your paradigm is actually pretty unique?

Krakow: I think that the sleep dynamic therapy approach is unique, in that it says there is much more going on in these patients than we previously admitted, or understood, or made attempts to observe.

I do see a lot of second opinion cases. I get patients from all over the country coming to our center and they are basically saying, well I went to my center and they gave me CPAP and it didn't work, and I want to know if you have something else to try; or if there is something about the way my insomnia was treated - they said just take these pills.

So, on the one hand there are lots of people out there that are practicing what's called behavioral sleep medicine, providing lots of cognitive behavioral therapy for patients. I do believe that what we offer in the way of sleep related emotional processing skills and the imagery work that we do, are a more complete approach to the psychological side of things. And I believe that by working on these physiological dimensions, such as the sleep breathing problems, it makes the picture more full in terms of what's going on.

My sense is that other sleep centers some of them are starting to move in this direction, but in general I don't know how easily they are geared to do that. My particular background is probably what has made me have the opportunity to do this, because I was trained as an internist, yet for the last twenty years because of my work with Dr. Neidhardt and Dr. Kellner, as well as with Michael Hollifield who was also at University of New Mexico at the time – because of those interactions I was working with mental health patients for the last twenty years, who all had sleep disorders. That's my specialty.

So I think what happened was, because as an internist I became very comfortable with the physiological side of things, I also had this incredible exposure and mentoring from all of these psychiatrists, and a few

psychologists from the field of sleep, helping me to learn more and more about the psychological side. And putting that all together I began to see that most insomniacs did not benefit, in my opinion, from only getting a restricted view of their insomnia, and only getting treatment in one area, and that's why I'm so strongly pushing for the idea that you give the insomnia patient the psychological and the physiological treatments together in whatever dosing that they can.

Dr. Dave: Are you doing any training? Are you (laughing) going to create some other Barry Krakows out there?

Krakow: I wouldn't want to wish that on the world (laughing), but with respect to training – it's interesting you mention that – we have our first workshop that is coming up on November 9th, 10th and 11th 2010, and what we are doing is we are training on our idea about the PTSD sleep clinic; we are giving training about the image rehearsal therapy for insomnia; but we have also got another day on November 11th where we are spending all day talking about the stuff that we are talking about here. Which is a half a day on sleep related emotional processing techniques, then a half a day on very complex sleep cases and what you can do to give that patient both the psychological and the physiological treatments that they need.

Eventually what I think we are going to be doing is both doing workshops onsite at our sleep facility at Albuquerque, but also going to other centers around the country, and in fact there are two workshops that are in development right now for Israel and Germany, for next summer.

So I think there is a chance for us to reach out and bring this style to other sleep centers, but it may be even more important in some ways for other therapists, because I think therapists have a tremendous opportunity to engage the sleep field by being more aware about sleep problems, and also doing some of these other techniques that are sleep related. When I say the imagery work, or the sleep related emotion-focused therapy.

Dr. Dave: OK, well I will be sure to put a link to your website in our show notes, and I will also mention the website address in my post interview comments, and I'm sure that people will be able to find information on your website about these workshops. Is that right?

Krakow: Absolutely.

We have lots of stuff on our website **www.sleeptreatment.com** that has a lot of information about the upcoming workshops, and of course a lot more

information about all the stuff we do with sleep dynamic therapy, the imagery work, sleep related emotional processing. Other websites that we have, because we have tried to branch out in a lot of areas, we have **www.nightmaretreatment.com** also **www.ptsdsleepclinic.com** and we have **www.sleepdynamictherapy.com**

All of these serve specific purposes for the particular type of patient and their interest, and the **www.sleepdynamictherapy.com** is my blog.

Dr. Dave: OK, well as we begin to close down here, you did mention pills at one point, and so I just want to touch on that before we close off. What is your take on Ambien and Lunesta and so on. I know I have certainly found them to be helpful at times, especially for international travel.

Krakow: My feelings about the medications are that they are wonderful drugs for certain people at certain times. But what I think about them goes far beyond that in terms of how I perceive them in clinical practice.

We just published two papers, one in the Primary Care Companion to the Journal of Clinical Psychiatry, and the other one is just coming out next month in the Journal of Nervous and Mental Disease. Both papers looked at samples of people who walked in the door who were regularly using Ambien, or Lunesta or some other drug such as Trazodone. Now on average these people were using these drugs for four years.

No surprise from what we have been talking about, what we found were two really obvious things. Number one, 70% to 90% of people in these two different samples – and both samples by the way were reasonably sized, one was about 130, the other was about 250 – 70% to 90% of these people had sleep breathing problems. That is one of the reasons they kept waking up at night, and why the medicine actually wasn't working that well. The second thing was these patients were terrible at emotional processing. They still had racing thoughts, they still were living in their minds, the drug was simply masking all of this and it worked temporarily but nobody for whatever reasons was addressing that this is what led the patients to getting on the pills.

It wasn't just a question that they needed some simple cognitive behavioral therapy, it was that these patients were very very poor at working with their emotions. Some of them had even been to therapists, and the therapists kind of threw up their hands and said, look you are just going to have to take a pill to help you sleep.

But the truth of the matter is in my opinion, is that these patients can work with therapists and sleep doctors who are willing to consider sleep related emotional processing, and the Thoughts, Feelings, Imagery paradigm, and you can actually get these patients over a period of time to get off these medications.

In *Sound Sleep* I have an entire section devoted to this concept of what it takes to kind of prepare yourself to get off the medication. It's not like it's an impossible thing to do, it's just that it takes time, because you really do have to, number one treat your breathing disorder if you have it; and number two you do have to learn to be better at improving your coping skills and being able to work directly with your emotions in a more honest and efficient way.

Dr. Dave: Plus I'll bet people develop a kind of psychological dependence, if not a physiological one, of feeling like, boy I need this crutch, if I don't take my pill I'm not going to be able to sleep.

Krakow: Well not only that, but let's come full circle. Once you have gotten dependent on these medications, you will lose your wave of sleepiness.

Dr. Dave: Yes.

Krakow: It is no longer something that you can attend to, because you are relying on the pill to create the wave of sleepiness, which it does, and it does effectively again for certain people, at certain times it is a miraculous drug. But most people really can learn to recruit the wave of sleepiness on their own, and when you teach them that, they will usually realize they certainly don't need these medications every night, and if they need them occasionally that's fine, that's the way that they were intended to be prescribed.

Dr. Dave: What about age? (laughing) You know, being on the end of the spectrum here, we sort of regularly hear that, oh well you are an older person, older people can't sleep through the night, they wake up during the night. Supposedly natural melatonin production drops off with age, so personally I have been taking melatonin as a supplement, and it seems to be helpful. So what's your take on that, as we get older are sleep problems inevitable?

Krakow: I don't think they are inevitable, but I will say this, that certain aging things, changes whether it's pro inflammatory states, or oxidative stress, whatever the thing that's going on with aging does seem to have an

impact on the way you breathe. So when you hear about people saying, I was sleeping just fine until I was forty, or fifty, or sixty, one of the first things to think about is not aging, it's to think about did aging do something that would cause you to have a sleep problem.

So two things come up physiologically that are very common: people who report the onset of sleep problems after the age of fifty or sixty almost always could have either a breathing problem, or a leg jerk or leg movement problem. Because there are tremendous correlations there and nobody knows for sure why this is, but there really is difficulty with the breathing maintaining itself correctly, or with the person not developing this leg jerk problem. Both of those will eventually cause terrible sleep quality problems and in a fair number of cases it will also cause insomnia.

Dr. Dave: Well there is so much more that we could keep talking about, but we should probably wrap it up here (laughing).

Krakow: OK, we've given enough to put people to sleep (laughing).

Dr. Dave: No, (laughing) well you've woken me up to some fresh ideas here, and I'm putting them into practice.

Krakow: I want to get you out here to get a sleep study, and have you see the whole process, and see whether or not you think the psychological and the physiological is relevant to some of your own rare bouts of insomnia.

Dr. Dave: Yes, well I would love to do that. Dr. Barry Krakow, thanks for being my guest today on Shrink Rap Radio.

Krakow: Thanks so much for having me David.

Other related podcasts in my Wise Counsel Podcast series at www.wisecounselpodcast.com

June 1st 2010 Interview with Dr. Leslie Greenberg and his Emotion-Focused Therapy (as mentioned by Dr. Krakow in this interview)

November 1st 2010 Interview with Dr. Krakow regarding his approach to treating PTSD and Sleep disorders