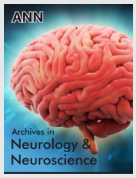

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Mini Review

Cognitive-Behavioral Therapy in the Treatment of Recurrent Isolated Sleep Paralysis

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In Russia, approximately every fifth person has experienced a state of sleep paralysis, which can be Isolated Sleep Paralysis or in the structure of post-traumatic stress disorder (for example, the loss of a significant person, a serious illness of a child), a large episode of depression and a reaction of grief (for example, in the process of separation) [1,2]. Patients describe this condition as a feeling that "the body is asleep, and the brain is working." It is as if they are seeing a "dream in a dream". When they wake up, they can't move their arms or legs, they feel that they are being held by their arms/legs, they are being pressed on their chest, they are holding their mouth. They can only open their eyes and observe the difference of vision: animals, "a person without a face", close people, dead people, "strange silhouettes". What they saw is interpreted as a paranormal, religious experience, supernatural attack, near-death experience, "feeling that they are going crazy", abduction/contact with someone and something. Patients begin to move the body by force, and as soon as they manage to move, push on something, the condition abruptly passes. They get up, walk and go back to bed and fall asleep. In the morning, patients forget a lot or everything, during the day there may be residual memories of the episode with a tendency to "symbolic interpretation" (dramatic mythical scenarios), the search for causes. There is somatization in the form of headache, irritable bowel, pain syndrome, fatigue. The anxious expectation increases (fear of the night, a repeat episode) [1]. The intense sensory and perceptual experiences suffered cause postepisodic distress from sleep paralysis (=SP postepisode distress), which leads to the development of a spectrum of avoidant and reinsurance behavior in the patient [2].

Speaking about the tactics of treating sleep paralysis, at the moment there are several options for pharmacological (for example, the use of escitalopram) and psychotherapeutic treatment for chronic and severe cases, but none of them to this day has irrefutable evidence of effectiveness. Test of the mental status of a patient with sleep paralysis is carried out using: PHQ-SADS, ISI, Sleep Paralysis Post-Episode Distress Scale, DASS-21 and Sleep Paralysis Experiences and Phenomenology Questionnaire (SP-EPQ). The patient is also asked to keep a diary of episodes of sleep paralysis: the perceived duration (sec / min), the fear associated with the attack, and the disorder caused by hallucinations (on a ten-point scale).

In our daily practice, we often use the protocol of muscle relaxation before bedtime for patients with sleep paralysis (Focused-Attention Meditation Combined with Muscle Relaxation therapy). It is aimed at teaching patients to perform four steps during an episode [3]:

- Reassessment of the meaning of the attack-a reminder to yourself that the experience is ordinary, favorable and temporary, and that hallucinations are a typical byproduct of dreams.
- Psychological and emotional distancing-reminding yourself that there is no reason for fear or anxiety and that fear and anxiety will only worsen the episode.
- Meditation of internal focused attention - focusing their attention inward on an emotionally engaging, positive object (for example, a memory of a loved one or an event, a hymn / prayer, God, a positive experience, to name 5 things that bring pleasure).

- Muscle relaxation - muscle relaxation, avoiding breath control.

Recently, a protocol of cognitive behavioral therapy (CBT) for the treatment of recurrent isolated Sleep paralysis (CBT-ISP) was proposed, which is aimed at reducing post-episodic distress from sleep paralysis: minimizing anxious ruminations about sleep, difficulty falling asleep, fear of falling asleep, improving cognitive functioning and mood background during the day. In Table 1, we present the structure of this protocol [2] (Table 1).

Table 1: Protocol of cognitive behavioral therapy for the treatment of recurrent isolated sleep paralysis by B. Sharless and K. Doghramji.

Stage	Description
1	• Self-monitoring of episodes of sleep paralysis using a modified sleep diary; • Psychoeducation about sleep paralysis: predisposing, provoking factors in the patient; • Representation of the cognitive-behavioral model of sleep paralysis, including a predictable "sequence" of episodes (for example, the cycle of symptoms, the role of maladaptive assessments, and an increase in the level of activation); • Practice during the session to discuss catastrophic thoughts related to both paralysis and hallucinations (with instructions for homework); • * An imaginary rehearsal of the destruction technique (for example, focusing on the mobilization of the finger / foot or trying to cough to promote the return of movement and dispel hallucinations) during the session. This is done when the patient is in a lying position on the couch. After an imaginary rehearsal, the patient is provided with instructions for the use at home and in vivo of these various methods of destruction during episodes of sleep paralysis.
2	• Use of personalized sleep hygiene (for example, ways to avoid sleep disorders, avoid lying on your back, limit the use of certain substances before going to bed, remove maladaptive avoidance behavior); • The use of diaphragmatic breathing, progressive muscle relaxation, meditation and / or mindfulness exercises to reduce the overall level of anxiety during the day • Instructions for preventing relapses are provided during the last therapy session using an approach based on coping strategies.
3	• Applied diaphragmatic breathing, relaxation, mindfulness or meditation during episodes of sleep paralysis with attempts to "stay calm" (for example, using a calming conversation with yourself, using distraction from hallucinations, re-evaluating the values of the episode / symptom) to interrupt and shorten episodes • The use of methods for interrupting an episode in vivo. If the initial attempt is ineffective, patients are instructed to flexibly apply methods of secondary destruction. • Early and early application of interrupt methods in a predictable sequence of episodes

As can be seen from Table 1, both forms of psychotherapy overlap in many ways. Both protocols pay special attention to various forms of relaxation, re-evaluation of symptoms, switching attention away from the content of the episode and the practice of interrupting while patients are in the supine position. It should also be noted that both approaches are based on cognitive behavioral models of panic disorder. The protocol of muscle relaxation before bedtime for patients with sleep paralysis prevents the patient from trying to move, whereas CBT actively encourages these attempts to directly disrupt episodes and distract attention from potentially frightening symptoms (for example, hallucinations). The first psychotherapeutic protocol is not aimed at breathing techniques, while in CBT it is as a potential source of relaxation that can be used "at the moment" of the attack. He is also against the use of such forms of relaxation as prayers, as he sees this as a reinsurance behavior that reinforces dysfunctional beliefs about the episode. The effectiveness of CBT. There is a decrease in episodes of sleep paralysis, minimization of anxious rumination about sleep, difficulty falling asleep, fear of falling asleep, improvement of cognitive functioning and mood background during the day. It also increases the sense of control over the episodes. Remission is 4-6 months [2].

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None.

Conflict of Interest

No conflict of interest.

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