Basic Principles of Integrative Sleep and Dream Medicine

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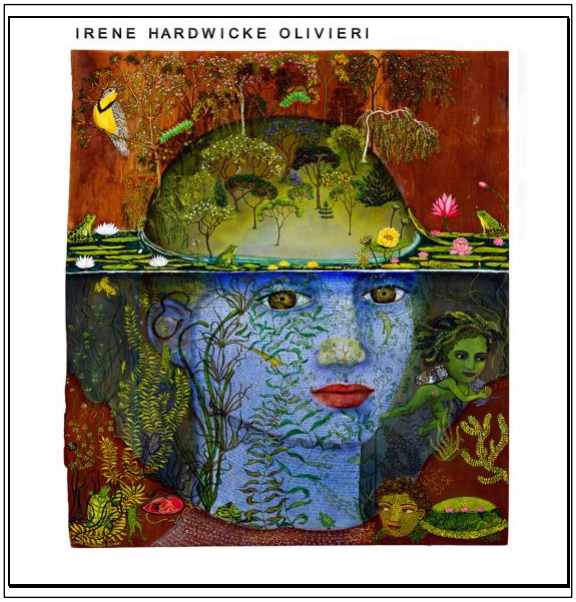

Based on the principles of integrative medicine (IM), integrative sleep and dream medicine (ISDM) is an emerging model for understanding, treating and preventing sleep disorders as well as for promoting sleep health. ISDM integrates efficacious conventional sleep medicine (CSM) with complementary and alternative medicine (CAM) approaches. It builds on the valuable contributions of CSM while compensating for its limitations, which have hindered further progress. ISDM reframes sleep and dreams as fundamental consciousness issues that call for a radical transformation of our understanding of sleep, dreams and waking as well as reconceptualizing sleeping, dreaming and waking as dynamic components of a unified higher consciousness.

Largely as the result of efforts on the part of Andrew Weil at the University of Arizona, IM research, training and clinical initiatives have been established in major universities and medical centers around the US and the globe. The limitations of conventional medical philosophy and care and the promise of increased effectiveness and lower costs are important factors in the spread of integrative medicine and are fundamental to ISDM.

I had been using the term *ISDM* in both clinical practice and in teaching at the University of Arizona Center for Integrative Medicine for several years before I formally introduced it in 2006 in my book *Healing Night: The Science and Spirit of Sleeping Dreaming and Awakening*. Andrew Weil and I further elaborated on the integrative approach to sleep and dream medicine in *Healthy Sleep*, a consumer audiobook we coauthored in 2007. I have subsequently used the term extensively in both public and professional presentations and writing.

A critical distinction between CSM and ISDM stems from their distinctive conceptualizations of sleep, sleep disorders and postures toward the sleeper. While CSM relies on an objective, medicalized view of sleep that presumes it to be unconscious, ISDM emphasizes the phenomenology of both REM and non-REM sleep. In doing so, ISDM restores regard for the sleeper, for the patient's personal, subjective experiences of and around sleep. ISDM also conceptualizes sleep in terms of an integration of its objective and subjective dimensions. CSM, however, has failed to call out pathological cultural force, paying inadequate attention to lifestyle factors and natural rhythms.

CSM's limited regard for sleep phenomenology is reflected in its subsumption of REM/dreaming[1] under the general rubric of sleep. This has relegated REM/dreaming to a subordinate position and has contributed to obscuring an epidemic of REM/dream loss. In contrast, the term *integrative sleep and dream medicine* is intended to restore parity to REM/dreaming.[1] This shift in perspective has significant ramifications for understanding, treating and preventing sleep disorders.

The purpose of this paper is to summarize the basic principles that inform ISDM:

1. Sleep and dreams are the roots of the tree of waking life.

Like the intricate and extensive root system of a tree, sleep and dreams live underground. As is with plant life, there is as much going on below the surface as there is above it. Essential for optimal health, well-being and spirituality, sleep and dreams are grounding, nourishing and healing. They are functional and utilitarian, but they also invite us to expand our awareness or consciousness beyond the realm of what is visible in ordinary waking. More than a cornerstone of health, sleep and dreams are fundamental to all aspects of life itself.

To be effective, healthcare providers need to deepen their personal understanding and experience of sleep and dreams and to move beyond common myopic presumptions that fail to recognize the magnitude of night consciousness.

2. Sleep is not an unconscious biomedical process.

Our conceptualization of sleep is inadequate. Just as we confuse intelligence with IQ, the measure of intelligence, we also conflate sleep with our measures of sleep, especially PSG. (Standards established for normal sleep are, furthermore, based on the study of people living in industrialized cultures with significantly disrupted circadian rhythms.) Although its contributions are vital, conventional sleep medicine defines sleep largely in terms of its physiological correlates. Paralleling our tendency to define health as the absence of disease, it defines sleep negatively, that is, in terms of what it is not. What is sleep? It's *not* waking, *not* awareness, *not* consciousness. Scientifically speaking, sleep is non-REM, *not* dreaming. But knowing what sleep is *not* does not tell us what it is. Reducing sleep to an unconscious physiological process also distances and depersonalizes it and sets sleep specialists up as gatekeepers. Such excessive medicalization imposes serious limitations on our understanding, treatment and prevention of sleep disorders. Conflating sleep with unconsciousness encourages dependence on medications that deliver unconsciousness, not sleep. Medicalization also erodes sleep self-efficacy—essential trust in our personal experience of, relationship with and ability to right our own sleep.

Healthcare providers should counter highly medicalized approaches and prioritize the restoration of sleep self-efficacy. Acknowledging the limitations of sleep medications is an essential step here.

3. Sleep is a personally accessible and profoundly serene default state of consciousness.

1 Although REM sleep and dreaming are generally viewed as independent constructs, this paper will use the terms *REM/dreams* and *REM/dreaming* to refer to their overlay.

In contrast to the presumption that it is impossible to have awareness of non-REM sleep,[2] emerging research confirms the position of ancient Buddhist and Hindu texts that suggest otherwise. We are capable of spontaneously experiencing or cultivating awareness of sleep—even deep sleep. Diverse spiritual and metaphysical writings[3] suggest that the conscious experience of sleep is profound serene, and ineffable. They further suggest that despite appearances, sleep does not alternate with waking—it underlies it. In other words, sleep is our default consciousness. It is ever present in our subconscious but occluded by the stimulation of waking life.

Liberating sleep from its captivity in the unconscious has significant implications for treatment. Acknowledging sleep phenomenology, the subjective dimension of sleep and dreams, can help restore our regard for the sleeper and encourage sleep self-efficacy. Ultimately, we come to realize that what we must do to access deep sleep also helps us access our deep Self.

4. Dreaming is a primary form of consciousness, not a subset of sleep.

Conventional sleep medicine's failure to meaningfully distinguish sleep from dreams—non-REM from REM sleep—has obscured the critical role of REM/dreaming in sleep, sleep disorders and general health. Given that it expands the frame of consciousness, REM/dreaming is especially relevant to mental health. Because it processes, digests and assimilates challenging waking life experiences, it is critical to memory formation and mood regulation. Dreaming also serves as the bridge to and from sleep as well as a portal to creativity and spirituality. Whether we believe they have objective meaning, our dreams are subjectively meaningful experiences that affect us in much the same way waking life does. Our culture's tendency to deny the value of dreaming may be symptomatic of oneirophobia, an underlying fear of the unconscious.

Subsuming dreaming under the rubric of sleep has veiled the fact that much of sleep loss is actually dream loss. CSM's limited regard for REM/dreaming has also undermined the long tradition of dreamwork in psychotherapy, diminished our sensitivity to the key role REM/dreams plays in the pathophysiology of insomnia and shrouded a striking epidemic of REM/dream loss. The role of REM/dreaming should routinely be considered in the treatment of all sleep disorders as well as in the promotion of sleep health. All healthcare providers need to be better informed about REM/dreaming. And all sleep health specialists should receive basic training in dreamwork.

5 Wake-centrism[4] is the primary cause of our fundamental misunderstanding of sleep and dreams.

We are oblivious to a profound and pervasive bias in our perception that waking is our sole primary form of consciousness. Consequently, we view sleep and dreams as secondary and subservient states of being. Wake centrism is a kind of flat-earth consciousness that discourages

[2] In his classic volume *The Promise of Sleep*, William Dement states, "It is impossible to have conscious, experiential knowledge of non-dreaming sleep; indeed, one of sleep's defining aspects is that we don't know that we are sleeping while we are doing it."

[3] See the work of Sri Auribindo, Rudolph Steiner, Ken Wilbur, and Eckhardt Tolle.

[4] Naiman, R. "Falling for Sleep" AEON (2016).

us from approaching the edges of our awareness. It is not a blind spot but a loss of peripheral vision. Wake centrism is not a way of seeing but a way of *not* seeing the bigger picture, the world behind the world. "A belief is not merely an idea the mind possesses," said Robert Bolt. "It is an idea that possesses the mind." Wake centrism is a ubiquitous core belief of modern life.

Insufficiently modulated by sleep and dreams, waking becomes relentless, fueling hyperarousal and insomnia. The treatment and prevention of sleep disorders requires considering the impact of wake centrism on healthcare professionals and patients alike.

6. We sleep with our surroundings—our communities, homes, bedrooms and bed partners.

Sleeping and dreaming are relational experiences that involve an intimate dance between the sleeper and their environment. In past times, we slept *with* the world around us—in close proximity to and in time with the people and places that constituted that world. Today, the places where we sleep and dream have been denatured, that is, segregated from the natural environment in which sleeping and dreaming evolved and still depend on. Consequently, we suffer from the nocturnal equivalent of nature deficit disorder—chronic and significant disentrainment from primary circadian zeitgebers, especially rhythms of light and darkness as well as ambient temperatures. And the places we sleep, our bedrooms, have become much less permeable to the natural nocturnal environment and much more polluted with stimulating residues of waking life, such as artificial light, toxic chemicals, and EMFs. There has, additionally, been a significant increase in couples opting for solo sleep over recent years.

ISDM emphasizes the need to comprehensively evaluate and address sleep environment issues. Night in nature provides an ideal model that is dark, cool, quiet and clean. And it is also edged with twilight—transitions through dusk and dawn that support parallel transitions in consciousness. Because it is associated with healthier relationships, ISDM encourages social sleep whenever feasible.

7. Natural rhythms and the continuity of consciousness define "the power of when."

Rhythms are the temporal infrastructure of everything, and they underpin the continuity of consciousness—of waking, dreaming and sleeping. Although circadian rhythms have received most of our attention, ultradian rhythms, especially those with ninety-minute periods, exert a less obvious but equally critical influence. If circadian rhythms represent the tides of daily life, ultradian rhythms are the waves that ride on top of them. Both rhythms are essential, and both are damaged by modern lifestyles. Associated with wake centrism, denaturation and, irregular sleep-wake schedules, many commonly used medications and substances further disrupt our natural rhythms.

Healthcare providers need to be better informed about circadian medicine and the role of rhythmic factors in treatment, prevention and health promotion. This is especially true for the treatment of sleep disorders. Helping patients tune in to their personal circadian and ultradian rhythms encourages sleep self-efficacy. Various practices that support rhythmicity, such as breathing techniques, heart math, and chanting,[5] can be useful complements to more conventional approaches.

[5] The yogic mantra *aum* (om) comprises three sounds: *a, u,* and *m,* which respectively represent waking, dreaming and sleeping, and is meant to enhance one's experience of a unified consciousness.

8. Insomnia is a symptom of our "addiction" to waking consciousness

Insomnia is the most prevalent sleep disorder, negatively affecting virtually all aspects of life for tens of millions of people. Despite dramatic increases in related research, clinical services and public health education, insomnia does not appear to be remitting. This is likely due to the denial of wake-centrism, our addiction to waking consciousness, which is manifests as hyperarousal. Because it also reinforces a wake-centric, fast-paced mindset, hyperarousal is fundamentally a disorder of consciousness and should be treated as such. We must heed Einstein's sagacious guidance that *no problem can be solved from the level of consciousness that created it.*

Current treatments for insomnia are limited in their effectiveness. Medications are largely symptom-suppressive and are associated with negative long-term outcomes. More natural botanicals and nutraceuticals can sometimes provide effective alternatives. CBTI remains a first-line treatment, but its effectiveness is also limited , especially with severe chronic insomnia. Sleep hygiene is necessary but insufficient as a stand-alone intervention. Given that much sleep loss is actually dream loss, it would make sense to complement sleep hygiene with dream hygiene.

Insomnia should be addressed comprehensively with sensitivity to relevant biomedical, psychological, social, cultural, environmental (circadian) and consciousness/spiritual factors. In addition to effective behavioral sleep medicine interventions, treatment should emphasize (1) the restoration of sleep self-efficacy—trust in the body's innate healing capacity, (2) mindfulness of waking factors impeding sleep as well as direct experience of sleep and dreams, (3) possible secondary gain[6], and (4) the value of a rapprochement with nature through camping.[7] Ultimately, treating insomnia requires a transformation of consciousness—a shift in thinking as well as a willingness to shift out of thinking.

9. Sleep and dreams are consciousness issues that call for a radical shift in perspective

Certainly sleep and dreams can be supported by science and medicine, but they should not be displaced by it. For too many, getting to sleep is an anxiety-driven paint-by-numbers regimen that interferes with the natural process of surrendering waking consciousness. If over relied on, sleep instructions as well as sleep tracking technology can erode sleep self-efficacy.

In parallel with current research around the potential of psychedelics in mental health, healing sleep and dreams requires a willingness to allow consciousness to expand. This begins with greater mindfulness about the limits of waking thought. The authentic experience of sleep and dreams cannot be captured and conceptualized within a wake-centric mindset. We cannot meaningfully study fish by pulling them out of the water. We must be willing to swim.

10. Professional support for sleep and dream disorders needs to be radically transformed

There is a severe shortage of both medical and psychological sleep specialists in the U.S. And on the whole we can do a much better job. We need more and better trained professionals, especially around sleep phenomenology and dreamwork. We need to broaden the scope of professionals qualified to treat sleep disorders to include PCPs, PAs, NPs, nurses,

[6] Naiman, R. 7 Good reasons to stay sleepless: insomnia and secondary gain. HuffPost, 2017.

[7] Stothard ER, et al. Circadian entrainment to the natural light-dark cycle across seasons and the weekend. *Curr Biol*. 2017;27(4):508-513.

psychotherapists and especially sleep and dream specialized coaches. Expanding options for web-based as well as group interventions could also prove helpful. Given the addictive features of insomnia, grass roots 12-step recovery programs may also be worth exploring.[8]

[8] Naiman, R. Insomniacs Anonymous: Do We Need a 12-Step Program for Sleep? HuffPost, 2011.