THE Energy Field
SPRING 2018

THIS ISSUE

Central Nervous System Apnea: A Breakthrough in Understanding and Treatment with Energy Psychology

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As of 2016, 22 million Americans were estimated to have sleep apnea.[1] Sleep apnea is the temporary cessation or suspension of breathing that occurs involuntarily and repeatedly during sleep and is estimated to shorten lifespan by 8-10 years. Long-term effects can be life-threatening because the risk of heart attacks and strokes increases dramatically with oxygen deprivation. There are two types of apnea, which are entirely different in causation, and one of them tends to be overlooked worldwide.[2] Central nervous system apnea (CNSA) is defined as a failure of the nervous system to signal the body to breathe, whereas obstructive sleep apnea (OSA) is caused by airway blockage and is currently viewed as the only statistically significant type in terms of occurrence.

The groups of people most likely to have undiagnosed CNSA are: combat veterans,[3] people who were given ether as anesthetic (ether is a solvent and a fuel i.e. a poison), and survivors of car accidents, near-drowning, and childhood abuse.

I became interested in the possible link between CNSA and PTSD in 2008, as a result of the following experience of working with a client.

Paul (not his real name), who was 55 years old and overweight, was diagnosed with, and fit the stereotype for, OSA. He had been using a CPAP (continuous positive airway pressure device) for 15 years although he said he had apnea for "as long as I can remember." He was told his apnea was so severe (35+ events per hour) that he would need the CPAP for life and that he was not a candidate for surgery. He found the CPAP claustrophobic but "better than suffocating." The most uninterrupted sleep

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[1] SleepApnea.org

[2] An online database search for CNSA in England, France, Canada and Australia showed statistics similar to the US: if CNSA is acknowledged to exist it is mentioned as a very low percentage of population. In contrast there are many websites providing OSA information.

[3] Colven, et. al., (2012) OSA and PTSD among veterans. Please note even this article does not address CNSA. This is an oversight that illustrates the value of Dr. Drewry's work

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he attained was 90 minutes with the CPAP.

In the course of a session, Paul revealed a near-drowning experience at age 6 and remembered thinking, ***"I'm going to die, and my family doesn't even see me."*** After one session in which this traumatic memory/response was resolved, he stopped using his CPAP and reported that he slept better and longer without it, but still had insomnia. Subsequently he had two more sessions to alleviate insomnia, after which he started swimming and working out. He reported still being apnea-free six years after his three sessions.

This case suggested two important ideas: the first, that he had been misdiagnosed as having OSA when instead, he probably had CNSA; the other, that his sleep apnea was caused in some way by a traumatizing experience. As a result, I began actively exploring the possible connection between CNSA and PTSD with other clients. Since then, I have worked with many cases of sleep apnea that have suggested a similar connection.

Retrospective review

Between 2008 and 2016, a very clear pattern emerged: I saw 90 self-referring clients who sought relief from symptoms of oxygen and sleep deprivation. All had either been told they stopped breathing during sleep or suspected it. All 90 individuals expressed a profound sense of loss of feeling safe and in control of their lives due to traumatizing events. While their life histories varied, they also all shared the experience of having a version of the thought "I am going to die" during a freeze response, within the traumatizing event.

Fifty-seven had been diagnosed with OSA; the remaining 33 felt they had apnea based on known symptoms or a partner's alarm at their interrupted breathing. Individuals who had four or more sessions of treatment over a period of 9–12 weeks, and who used EFT combined with NLP every night before sleep, experienced significant results. People who followed this protocol and listened to the session recordings had the best results.

Table 1 summarizes reported symptoms of apnea prior to sessions. Table 2 summarizes the reasons these individuals contacted me for help.

Table 1. Reported symptoms of apnea prior to sessions

Symptoms	Number	%
Experiencing varying degrees of fatigue, brain fog, headaches, inability to function, and falling asleep in afternoon	90	100
Prescribed a CPAP machine	57	63
Using a CPAP machine	29	32
Waking spontaneously because they have stopped breathing	47	52
Sleeping through their apnea events (but their partner hears them)	28	31

Table 2. Associated conditions

Condition	Number	%
Panic or anxiety (diagnosed or self-reported)	64	71
Depression (diagnosed or self-reported)	57	63
Shallow daytime breathing or memory of intentionally holding breath	48	53
Apnea symptoms worse lying on back	42	46
Post-traumatic stress (diagnosed or self-reported)	33	24
Bruxism	28	32
Overweight	19	21
Post-nasal drip at night	18	20

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Results, summarized as percentages of 90 people:

- 10% chose not to proceed after a 30-minute consultation.
- 5% were immediately referred to their MD for adrenal/thyroid testing. Clients with post-nasal drip were immediately referred out for food and chemical sensitivity testing.
- 20% experienced relief from lingering effects of trauma, but they did not follow through long enough to stop apnea.
- ***35% of clients experienced immediate cessation of CNSA after the first session*** and remained free of it. In these cases it appeared that OSA was not the correct diagnosis.
- 30% experienced immediate relief from apnea but lapsed back into it without finishing the clearing/reframing process.
- Approximately one quarter of the 90 clients had a combination of OSA and CNSA, and while they felt emotional relief from traumatizing events, airway obstructions still interfered with their breathing. They still benefited from resolving lingering effects of traumatizing event, and they expressed a sense of having more control over their own lives and an enhanced ability to make wiser life choices.

In 2013, I met neurologist Ralph Rynes, MD and explained my theory and methods. He knew about EFT and had seen it effectively used, and so was open to my approach. I asked which neurotransmitter might be involved in CNSA and he made the following observations:

"I teach 4th year psychiatry residents about trauma, and I identify sleep apnea as a potential symptom of trauma. I think as physicians we focus too much on obstructive sleep apnea and are too quick to recommend a sleep specialist who automatically puts them on a CPAP.…my personal inclination is that the orexin (hypocretin) pathway is involved. The hypocretins are involved in the sleep/wake cycle and how glucose regulation is affected during sleep, as well as the GABA and glutamate pathways."

My hypothesis is that the success achieved in my treatment approach lies in resolving the freeze response associated with the trauma. The *perception* of imminent death during a traumatizing event is *interpreted as fact* by the subconscious mind via the freeze response, which then gives the "directive" to create a *"stop-breathing program"* in the autonomic nervous system, possibly via the activity of the neuropeptide *orexin*.[4] After the trauma is over, the *stop-breathing program* becomes a lingering but faulty survival mechanism in direct opposition to the body's innate directive to breathe continuously during sleep, resulting from archived traumatic memories that subconsciously run continuously.

I have identified two types of "stop-breathing" survival programs: deliberate and non-deliberate. About 50% said they tried to stop breathing to avoid inhaling water or toxins, or to make themselves less obvious to a threat. A "stop-breathing" command which is not deliberate would occur, for example, in a situation where the person is not directly in danger but is witnessing a traumatizing event happening to another person (or living being). An example of this is a child witnessing a sibling being beaten or otherwise abused by a parent, but feeling helpless to intervene. This activates the fight/flight/freeze response and an involuntary inhale occurs, followed by holding breath for a few seconds. I suspect this distinction is important for future research. In either case, it is the freeze response and subsequent re-enactment feature of PTSD that is the key factor in this hypothesis. *Note: this report was published in its entirety with case studies (Drewry, 2017) and can be viewed online.*[5]

How trauma may cause CNSA: archiving memories during the freeze response

The fight/flight/freeze response happens too quickly for conscious awareness. When neither fight nor flight is possible, the individual becomes frozen in fear and unable to deal with the threat.

However, before the cascade of chemicals produced in a fight/flight/freeze response return to normal levels, the

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[4] Orexin, a key neuropeptide, is thought to control involuntary body functions including breathing, blood pressure, heartbeat and blood sugar (Nattie and Li 2012). illustrates the value of Dr. Drewry's work

[5] Drewry (2017) http://www.ijhc.org/2016/12/central-nervous-system-apnea-can-be-caused-by-traumatizing-events-and-it-can-be-resolved-damaris-drewry

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methods of escape from a threat—or failure to escape it, are archived for future reference along with other new subconscious programs related to the perceived threat. The archived memories may include or even be based on faulty decisions, commands or interpretations of the dangers and how to most effectively respond to them. This process is true for many types of trauma and many psychosomatic conditions that result from unresolved trauma. Levine says: "It's about energy: traumatic symptoms are not caused by the "triggering" event itself. They stem from the frozen residue of energy that has not been resolved and discharged." (1997)

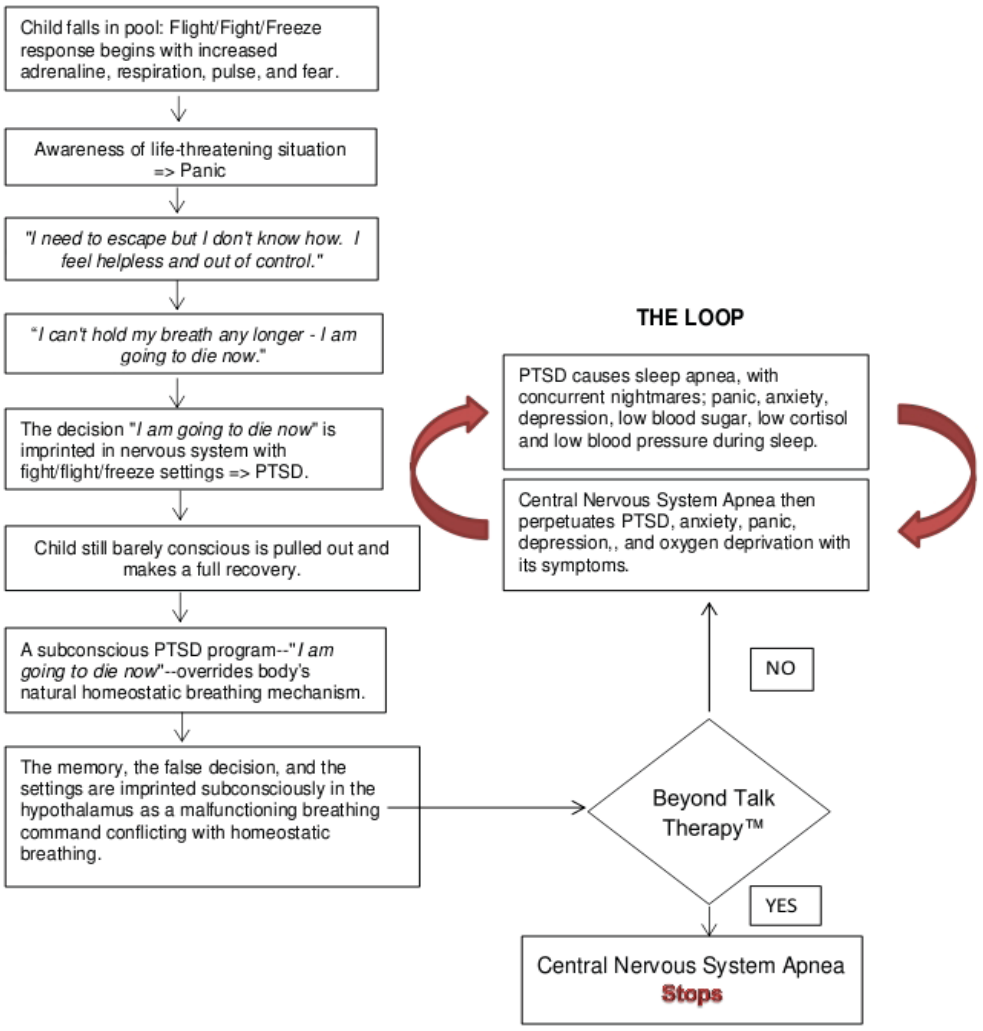
Re-enactment of trauma: the driving mechanism of CNSA?

During the freeze response, the experience, along with meaning given to the experience, is stored in cellular memory via neurotransmitters and re-experienced as if that event is still happening.[6] I propose that decisions made during specific types of breathing-related traumatizing events are re-lived as post-traumatic stress disorder (PTSD), which sets up a subconscious program that interferes with sleep. PTSD continues to run that subconscious, stop-breathing program until the brain can be made to realize that those events are no longer a threat to survival. The body, mind, and emotions must agree that the threat no longer exists in order to extinguish the subconscious programming.

To breathe or not to breathe

Figure 1 illustrates the panic-stricken thoughts and decisions people make during an event when they feel that death is imminent. In effect, they make a version of this decision that appears true at the time: "I am going to die now because I cannot escape this threat". The original faulty perception (decision) *"I am going to die now"* was archived in the limbic brain during the original trauma, for example, when the individual has held his breath as long as possible and can no longer prevent an in-breath. This is important in situations such as near-drowning, trying to avoid a threat

Figure 1 Resolving Sleep Apnea: The Living-Dying Loop Program



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[6] Pert (1999).

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by being extremely quiet (combat or childhood abuse), or resisting taking in toxic air, anesthetic, or amniotic fluid (viz. a fetus in a mother who smokes cigarettes). The command then is: *stop breathing in order to stay alive!* The "stop-breathing" program can successfully be extinguished by convincing the subconscious mind that the original traumatizing event is no longer happening and that the "stop breathing" command is no longer valid.

Methods

It isn't what happens to us that traumatizes us, it is the meaning we give to the event that affects every aspect of our lives.

My preferred approach to clearing energy that has been frozen in the body in response to traumatizing events is a combination of Emotional Freedom Techniques™ (EFT) and Neuro-Linguistic Programming™ (NLP). Sessions for all clients, including apnea clients, involve working through layers of decisions made about self and safety in the world during traumatizing events.[7]

NLP has three component concepts that are effective for reframing memories and remediating conflict between the body, mind and emotions (Bandler and Grinder, 1982):

- Neuro: perception of events through filters of experience
- Linguistic: the meaning given to events and the words used to describe the experience
- Programming: the way one behaves based on interpretation of events

Apnea clients are asked to assign a SUDS[8] level to their issues during and after sessions and they are taught to create short paragraphs specific to their life history to speak out loud while tapping before going to sleep. Tapping statements are changed daily or weekly to address newly-surfaced memories or insights. Clients who record their sessions and listen to them at least once, and who have 4-5 sessions over a six-month period have the best long-term results.

Tips for practitioners

Many people using EFT get tripped up by wording. Be sure to use your client's own words when you offer a tapping statement. Don't worry about stating "negative" things: it is important to acknowledge what is truly being experienced in present time before attempting to reframe meaning given to events of the past.

Ethical considerations

It is important not to offer false hope to sleep apnea sufferers. While it is true that clearing the lingering effects of traumatizing events may afford your clients significant relief it may not partially or totally remediate sleep apnea.

Avenues for future research

This retrospective review of 90 case studies brings CNSA into a spotlight for review in its related fields of neurology and sleep medicine. At this point we are dealing with a phenomenon, and results based on self-assessments of symptoms' intensity before and after self-healing interventions. Given the numbers of traumatized people in the world, it is not unreasonable to suggest that millions of people have undiagnosed or improperly diagnosed CNSA. The next step is to follow this protocol with before-and-after laboratory sleep studies and include assessments for PTSD and endocrine-related[9] stress factors (the Holmes and Rahe Stress Scale). ■

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[7] It is assumed that the reader is aware that EFT was accepted by the VA for PTSD in veterans in 2017 (Church et. al.)

[8] "SUDS" is an acronym for Subjective Units of Distress Scale, which was developed in 1969 by Joseph Wolpe to convey levels of distress. EFT recognizes 10 points on the scale, ranging from zero (no stress) up to ten (maximum distress).

[9] Van Liempt et. al. (2012). Sympathetic activity and hypothalamo-pituitary-adrenal axis activity during sleep in post-traumatic stress disorder: A study assessing polysomnography with simultaneous blood sampling.

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