Understanding and Treating Insomnia

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The author Ernest Hemingway had this to say about sleeplessness in his 1933 novel *A Clean and Lighted Place:* “He would lie in the bed and finally, with daylight, he would go to sleep. After all, he said to himself, it is probably only insomnia. Many must have it.” Hemingway, who suffered from bouts of insomnia throughout his life, was correct in assuming that he was not alone in his struggles. About 30% of the population has at least one symptom of insomnia, making it a common complaint in medical and psychiatric settings (Roth T, *J Clin Sleep Med* 2007;3(5 Suppl):S7–S10). Since insomnia is both a symptom of and a risk factor for many other conditions, we sometimes overlook insomnia as a stand-alone diagnosis.

The *DSM-IV-TR* defines primary insomnia as a disorder characterized by difficulty initiating or maintaining sleep, or having nonrestorative sleep, for at least one month. In addition, this sleep difficulty must:

- be associated with clinically significant distress or impairment;
- not occur exclusively during the course of another sleep or other mental disorder; and
- not be due to the direct effects of a substance or general medical condition.

DSM-5, scheduled for publication in May 2013, eliminates the distinction between primary and secondary insomnia. See details in “Sleep-Wake Disorders: Changes in *DSM-5*.” (https://carlatbehavioralhealth.com/sleep-wake-disorders-changes-dsm-5)

The estimated prevalence of primary insomnia in population-based adult samples falls between 1% and 10%, with rates of up to 25% in the elderly, and higher rates in women than in men, according to *DSM-IV.* Older patients tend to have more frequent awakenings throughout the night and in the early morning than younger patients, according to the manual.

How It All Starts

While patients who are afflicted by insomnia may report a history of light or easily disrupted sleep, the onset of the disorder is often fairly sudden and coincides with a stressful time or life event. The sleep disturbance typically persists after the stressor is resolved and patients report becoming preoccupied with the fear of not sleeping well, leading to a perpetuating cycle of insomnia and worry, consistent with a cognitive model of the condition.

Physiologically, insomniacs live at a heightened arousal level during the day and night, which may further contribute to sleep difficulties. They have significantly higher metabolic rates and average heart rates than normal sleepers, in addition to decreased heart rate variability (Roth op cit).

As one might expect, the struggles of poor sleepers are not limited to nighttime. They commonly complain of daytime fatigue, tension, and decreased concentration and attention. Patients with insomnia have higher rates of absenteeism and work-related accidents than normal sleepers (Leger D et al, *Sleep* 2002;25(6):625–629).

Insomnia takes its toll in many ways. Mean total health costs for individuals with insomnia are as much as 60% higher than those of non-insomniacs, a finding that highlights the fact that insomnia impacts more than a patient’s quality of life (Simon GE and VonKorff M, *Am J Psychiatry* 1997;154(10):1417–1423). Up to 40% of patients with insomnia have comorbid psychiatric diagnoses, the most common conditions being mood and anxiety disorders, which may precede or follow the onset of insomnia symptoms.

When a patient presents with the chief complaint of difficulties with sleep, practitioners should obtain a thorough history to characterize the problem. Practitioners may ask patients to keep sleep logs to track how long they are sleeping (including naps), how often they are waking up, and their sleep quality over one to two weeks, to account for any night-to-night variation. Insomnia is a clinical diagnosis, so polysomnography, which measures brain, eye, and motor activity during sleep, is not indicated unless there is concern for another sleep disorder.

What Distinguishes Insomnia Disorder from Other Sleep-Wake Disorders

Whereas *DSM-IV-TR* separated primary insomnia from secondary causes of insomnia, *DSM-5* will drop this distinction. As such, it will no longer be necessary to rule out medical causes of the sleep disturbance, such as chronic obstructive pulmonary disease (COPD), hyperthyroidism, or congestive heart failure, since the diagnosis, “sleep disorder related to another medical condition,” will be eliminated from the new manual. Similarly, “sleep disorder related to another mental disorder” will not be included in *DSM-5,* given that the interactive effects of insomnia and other disorders make it hard to presume causality. A complete history and physical examination are still the first steps in evaluation of a chief complaint of insomnia, since treatment of comorbid medical or psychiatric illness is key in the treatment of the sleep disturbance.

People who complain that they cannot sleep for more than seven or eight hours per night may be “short sleepers” who simply require less sleep than most people without the typical adverse effects of shortened sleep. These individuals do not meet criteria for a sleep disorder and practitioners may reassure them that they don’t need to spend additional hours in bed. Hypersomnia should be considered as a differential diagnosis when daytime fatigue is the predominant complaint. Other sleep disorders to consider as differential diagnoses for insomnia include circadian rhythm sleep disorder, narcolepsy (which is associated with hypocretin deficiency), breathing-related disorder, and parasomnias, which are characterized by behavioral events rather than by insomnia.

Finally, it is crucial to consider a substance-induced sleep disorder in patients with insomnia by asking about prescribed medications, substances of abuse, and toxin exposure. Patients may neglect to tell practitioners about their daily coffee habit, so it is important to ask about caffeine and related substances as well.

Treatment of Insomnia

Once a diagnosis of insomnia disorder is established, the first step in treatment typically focuses on behavioral modifications and therapies. Sleep hygiene techniques (see “Sleep Hygiene Tips” (http://carlatbehavioralhealth.com/wp-content/uploads/Sleep_Hygiene_Tips.pdf)) have been shown to improve sleep. However, there have been no placebo-control trials examining this effect (Stepanski EJ and Wyatt JK, *Sleep Med Rev* 2003;7(3):215–225).

Table 1: Sleep Hygiene Tips
Click here to open pdf (http://carlatbehavioralhealth.com/wp-content/uploads/Sleep_Hygiene_Tips.pdf)

Stimulus control entails encouraging patients to go to bed only when they are ready to sleep and to leave their beds if they are awake for 20 minutes or more, in order to uncouple their beds from the associated fear of not sleeping. Progressive muscle relaxation and the relaxation response are techniques that patients can learn and use nightly when they lie down for bed.

Sleep restriction treatment uses sleep deprivation to limit the patient's time in bed, based on calculated sleep efficiency (reported time asleep divided by reported time in bed). Time in bed is restricted to a duration that enables good sleep efficiency (eg, at least 85% or 90%). To achieve this, it may be necessary to restrict time in bed substantially (ie, to enable a greater proportion of that time to be spent sleeping). A wake-up time is selected, and remains constant throughout the sleep restriction therapy. If it is determined that good sleep efficiency occurs if the patient is restricted to four hours of time spent in bed prior to the 6 am wake up time, the initial bedtime is set at 2 am. For example, a patient is instructed to go to bed 15 to 20 minutes earlier each night, until he or she starts having trouble sleeping. So, the patient starts by going to bed at 2 am and gets up at 6 am. On night two, he or she goes to bed at 1:45 am and gets up at 6 am. As long as the patient does not have trouble sleeping, the bedtime is made earlier each night. The waking schedule remains the same (eg, 6 am).

Let's say that on night five, he or she goes to bed at 1 am, but starts having trouble sleeping. The patient then goes back to where he or she was able to sleep solidly and remains with that bedtime for a few days before trying again to add more time.

Cognitive behavioral therapy may combine several of the above mentioned techniques in a more structured weekly program to target insomnia.

Common medications used to treat insomnia include benzodiazepines, nonbenzodiazepine sedatives, and melatonin agonists. (See "Pharmaceutical Treatment of Insomnia.")Certain antidepressants with sedating properties, such as trazodone and amitriptyline, may be particularly useful in patients with comorbid depression. Over-the-counter

antihistamines and atypical antipsychotics are sometimes used to treat insomnia; however, routine use of these medications is not recommended due to a lack of clear effectiveness and their associated side effect profiles.

TCRBH's Take: There are many ingredients that go into the treatment of insomnia. Treating insomnia with medication tends to produce the quickest results. However, the longest-lasting results tend to stem from learning approaches that change one's perceptions and habits. And when both medication and nonmedication treatments are used, the degree of effectiveness can be influenced by timing—that is, knowing when discontinuing medication can enhance the effectiveness of a cognitive behavioral approach. (Or, put another way, knowing when continuing to have the option of taking a sleep medication can hinder a patient's effective application of a cognitive behavioral approach.) See "Is CBT Plus Medication the Best Treatment for Insomnia?" (https://carlatbehavioralhealth.com/cbt-plus-medication-best-treatment-insomnia)

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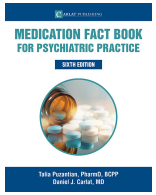

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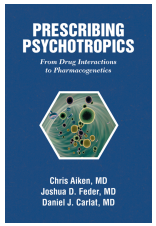

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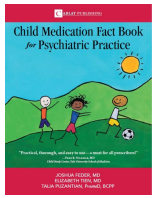

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