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Insomnia that Occurs in the Tricky Terrain of Mental Health Conditions: What to Tackle and How.

ASA Vic Branch

Sleep Meeting

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Monash University

Outdated notions of “primary and secondary” insomnia

- DSM-IV classified ‘primary’ and ‘secondary’ insomnia
- Since 2013 the DSM-5: “Sleep disorders coexist with other medical and psychiatric disorders and may not be mutually exacerbating”.
- The 2013 DSM-5 updates underscores the need for ‘independent clinical attention of a sleep disorder regardless of mental or other medical problems that may be present’.
- DSM-5 also recognizes that coexisting medical conditions, mental disorders, and sleep disorders are interactive and bidirectional.

Do you tackle the chicken or the egg?

Doesn't matter what came first there is a 'clearly recognised need for independent treatment of insomnia regardless of origin and comorbidities"

We know that poor sleep can be a predictor of future mental health difficulties

- “Sleep difficulties and the development of depression and anxiety: A longitudinal study of young Australian women”. Mel Jackson et al (2014)
- 9,683 young women from the Australian Longitudinal Study of Women's Health was analyzed.
- Women were surveyed in 2000 (aged 22 to 25 years), 2003, 2006, and 2009
- Significant increased risk of new onset depression (odds ratio (OR)=2.6 in 2003; OR=4.4 in 2006; OR=4.4 in 2009) and anxiety (OR=2.4 in 2006; OR=2.9 in 2009) was found at each follow-up survey in women who reported sleeping difficulties "often" in 2000.

Nat Sci Sleep. 2018; 10: 377–383.
PMCID: PMC6223387
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PMID: 30464665

The DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure identifies high levels of coexistent psychiatric symptomatology in patients referred for insomnia treatment

Hailey Meaklim,[1,2] John Swieca,[1] Moira Junge,[1] Irena Laska,[1] Danielle Kelly,[1,3] Rosemarie Joyce,[1,3] and David Cunnington[1]

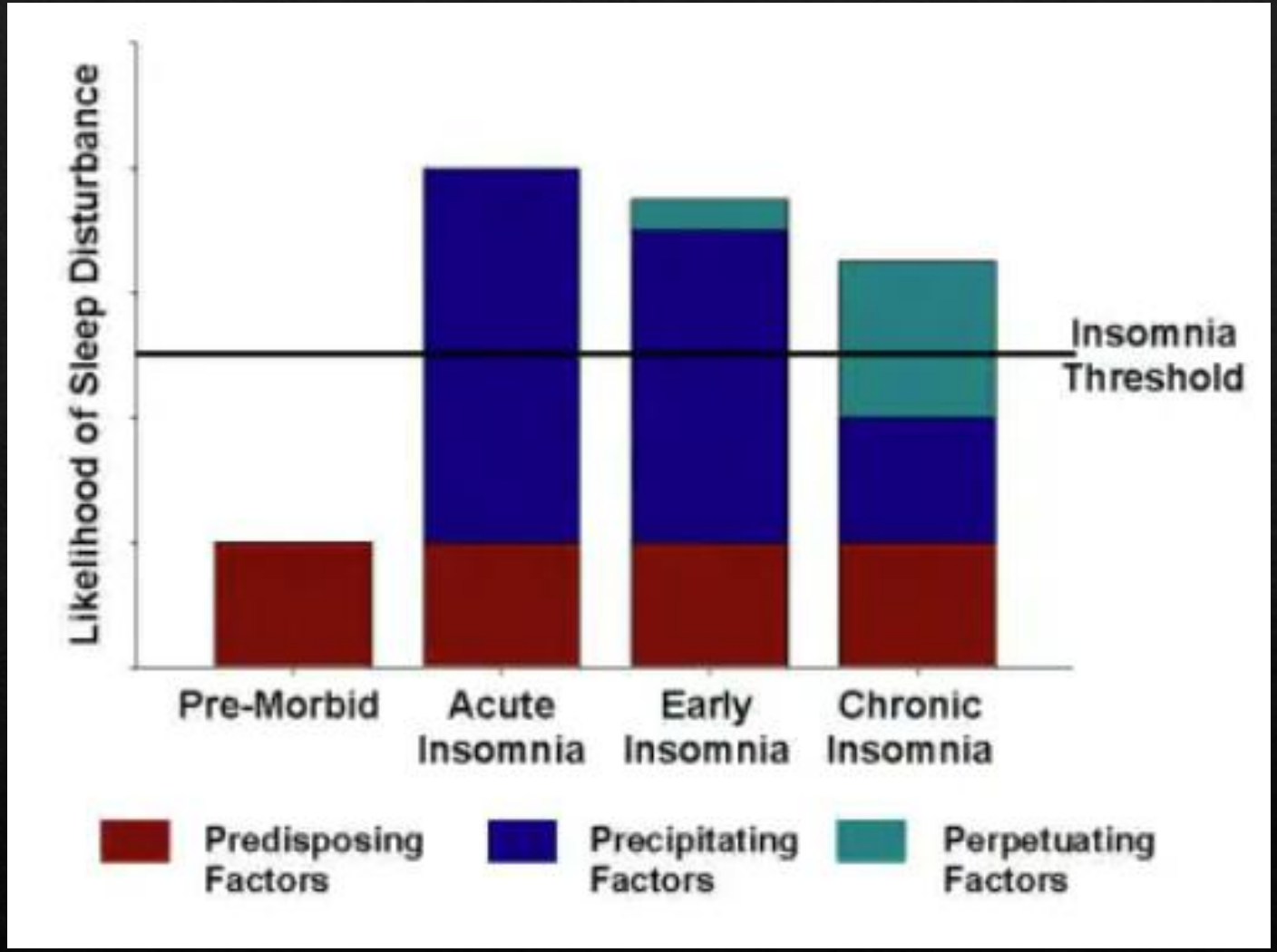
- It's no surprise to you all that there are high levels of comorbid psychopathology within people experiencing insomnia
- There is a well-described bi-directional relationship

Symptomology detected by the DSM-5 CCSM

- Anxiety 66%
- Depression (64%)
- Anger (64%)
- Somatic symptoms (50%)
- Suicidal ideation was acknowledged by 26% of patients.
- 82% of patients had at least one diagnosed comorbidity upon referral (eg, psychiatric, physical health, or other sleep disorder).

Educating your patient about their insomnia

- We all have X amount of predisposing factors that remain consistent
- Stress or illness puts us above threshold into acute insomnia
- We bring in certain behaviours or habits to combat the acute insomnia
- These factors ironically become the elements that are perpetuating the insomnia



CBTI- what is it?

Cognitive behaviour therapy for insomnia

Intervention	General description	Specific instructions
Stimulus control	BED = SLEEP. Set of instructions aimed at conditioning the patient to expect that bed is for sleeping and not other stimulating activities. Only exception is sexual activity. Aim is to promote a positive association between bedroom environment and sleepiness	Go to bed only when sleepy/comfortable and intending to fall asleep. If unable to sleep within what feels like 15–20 minutes (without watching the clock), leave the bed and bedroom and go to another room and do non-stimulating activity. Return to bed only when comfortable enough to sleep again. Do not read, watch television, talk on phone, pay bills, use electronic social media, worry or plan activities in bed
Sleep-restriction therapy	Increases sleep drive and reduces time in bed lying awake. Limits the time in bed to match the patient's average reported actual sleep time. Slowly allows more time in bed as sleep improves	Set strict bedtime and rising schedule, limited to average expected hours of sleep reported in the average night. Increase time in bed by 15–30 minutes when the time spent asleep is at least 85% of the allowed time in bed. Keep a fixed wake time, regardless of actual sleep duration
Relaxation techniques	Various breathing techniques, visual imagery, meditation	Practise progressive muscle relaxation (at least daily). Take shorter relaxation periods (2 minutes) a number of times per day. Use breathing and self-hypnosis techniques
Cognitive therapy	Identifies and targets beliefs that may be interfering with adherence to stimulus control and sleep restriction. Uses mindfulness to alter approach to sleep	Unhelpful beliefs can include overestimation of hours of sleep required each night to maintain health; overestimation of the power of sleeping tablets; underestimation of actual sleep obtained; fear of stimulus control or sleep restriction for fear of missing the time when sleep will come
Sleep hygiene education	Emphasises environmental factors, physiological factors, behaviour, habits that promote sound sleep	Avoid long naps in daytime — short naps (less than half an hour) are acceptable. Exercise regularly. Maintain regular sleep–wake schedule 7 days per week (particularly wake times). Avoid stimulants (caffeine and nicotine). Limit alcohol intake, especially before bed. Avoid visual access to clock when in bed. Keep bedroom dark, quiet, clean and comfortable

Only got 15 mins with the patient?

- 97 patients were randomized to Simplified Sleep Restriction Therapy
- At 6-month follow-up, SSR participants had significantly improved PSQI, ISI scores, actigraphy-assessed SE% and reduced fatigue compared with controls.
- SSR produced higher rates of treatment response (controlling for age, sex, and severity of insomnia)

- ***"Simplified sleep restriction for insomnia in general practice: a randomised controlled trial***
- ***Karen Falloon, C Raina Elley, Antonio Fernando, Arier C Lee and Bruce Arroll***
- ***British Journal of General Practice 2015; 65 (637)***

Brief behavioural therapy can be done by sleep physicians and GPs

› Aust J Gen Pract. 2021 May;50(5):287-293. doi: 10.31128/AJGP-04-20-5391.

A step-by-step model for a brief behavioural treatment for insomnia in Australian general practice

Alexander Sweetman [1], Nicholas A Zwar [2], Nicole Grivell [3], Nicole Lovato [4], Leon Lack [5]

Case Study 1

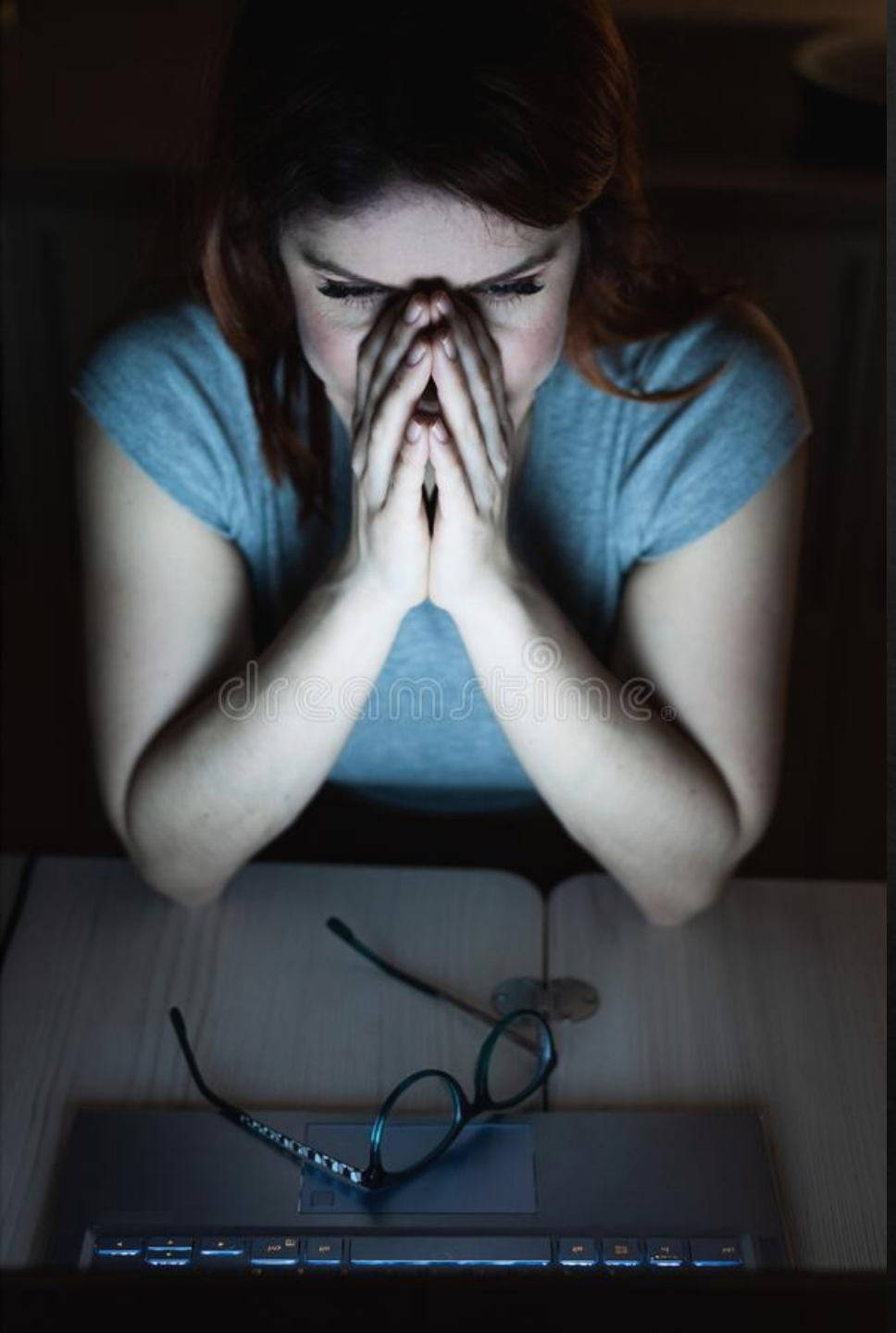
John, a 53-year-old man, is referred to your sleep disorders clinic for evaluation of insomnia and daytime sleepiness. He has been struggling with depression and anxiety, for which he is already being treated (via GP). John reports that he has had insomnia for many years and that it become worse in the past 10 years. He has trouble with sleep initiation-it often takes him more than two hours to get to sleep. Once he is asleep, he wakes up multiple times then struggles to get back to sleep. He tosses and turns in bed until morning and gets up feeling tired and exhausted.

His primary care physician prescribed zolpidem, but this caused sleepwalking episodes, so John discontinued it. Mirtazapine was tried, but it caused weight gain and he saiand fluoxetine for depression. This combination has been helpful, but he still has persistent symptoms of insomnia and depression. His wife reports that he snores d he felt sick and was also discontinued. He takes temazepam for insomnia and there have been occasions when he stopped breathing while sleeping. He is obese, has comorbid type 2 diabetes mellitus, hypertension, and gastroesophageal reflux.

Obstructive sleep apnoea is diagnosed on the basis of clinical and polysomnographic evaluations. John is treated with CPAP. He reports improvement in his energy level during daytime, but he continues to struggle with insomnia. His night-time awakenings decreased to 2 or 3 times and nocturia is diminished as well. Despite these improvements, he still struggles with insomnia. What do we do about his insomnia? You can’t get him into a psychologist and he rejects the idea of all digital therapies.

Case Study 2

Thuy is a 40-year-old schoolteacher who complains of an inability to sleep well for more than 10 years. Her GP sent her to your sleep disorders clinic as she is a snorer as well as someone with likely insomnia. She regularly goes to bed at 10 pm but is unable to sleep until 1 am. She experiences about 3-5 awakenings every night and with each awakening requires at least 30 minutes to fall asleep again. Thuy also experiences daytime fatigue and is unable to concentrate in her work. She reports she feels anxious and has had panic attacks with increasing frequency and has had depressive episodes periodically throughout her life although reports that feels 'numb' rather than depressed per se at the moment. She feels that the sleep problems are related to her depression as she had post-natal depression and feels that sleep has never quite been the same since the kids were born. She does not take naps during the day. She takes 6.25mg of Stilox nocte, often 12.5mg. She finds teaching stressful, has 2 children aged 8 and 10 and was recently divorced just before COVID-19. As bedtime approaches, she becomes very tense and worries about the prospect of another sleepless night. "Sleep has become a real frustration. Every night, when I lie in bed, I have to try very hard to sleep. I keep watching the clock, and realise how much I am racing against the clock to get some decent sleep". How do we help Thuy?

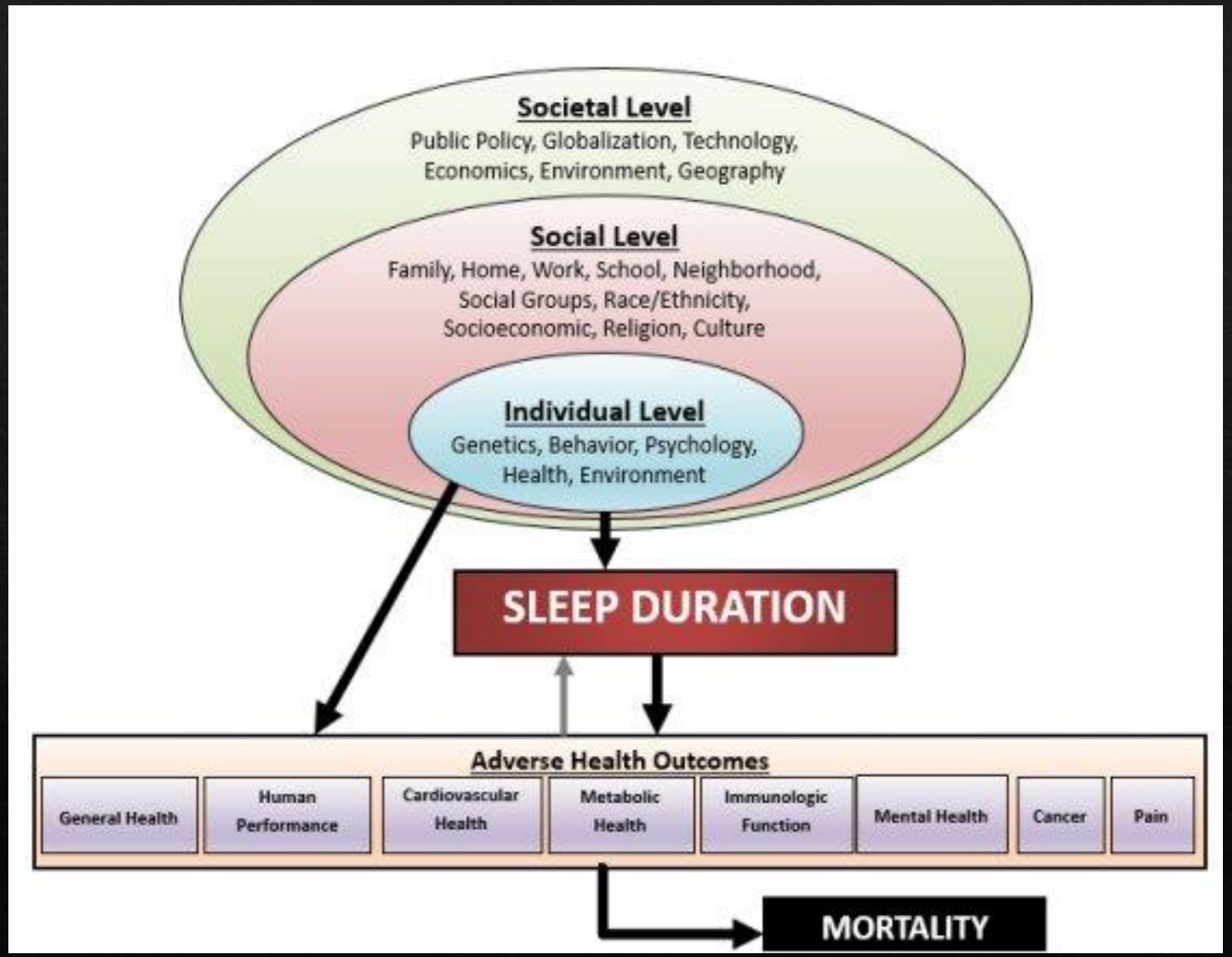


How will we improve our offerings to people with comorbid insomnia?

- We will educate and empower the patient
- Sleep is the most modifiable element of their health but it will take time and patience
- Help them to take the desperation away, or dampen the desperation as it contributes as very good fuel for the internal fire that's brewing
- Collaborate more in multi-disciplinary teams

Do what you can!

- Both patient and practitioner need to take the pressure of themselves to “fix” the problem
- As this diagram illustrates there are many things outside of your control



Summary

- Clinicians across the board should evaluate their psychiatric patients for sleep problems.
- All clinicians across the board should also evaluate their patients who present with complaints of insomnia for comorbid psychiatric/psychological problems
- CBTi will reap rewards for almost all people- just a matter of degree and a matter of managing expectations of what is possible
- Even small components of CBTi in small chunks can be helpful if a full-blown course of it is not possible