

On-the-spot management

INFORMATION FOR HEALTH PROFESSIONALS



Insomnia

Definition

Insomnia is the most common sleep disorder affecting up to 40-50% of the population at any given time. It is a distressing difficulty with sleep onset, sleep maintenance, or waking too early where these 'sleep times' take longer than 30 minutes. These symptoms need to occur at least three times or more per week and have been present for more than 3 months to be defined as chronic.

Acute insomnia (lasting 24-48 hours) is commonly associated with stress/family/relationship/financial situations and/or jetlag. However it can easily develop into a chronic condition from these predisposing factors

Of importance is the individual has a 'normal' opportunity to sleep – attempting sleep in bed for approximately 7 hours or longer. These combined symptoms negatively impact on the individual's quality of life which is further exacerbated by physical and psychiatric comorbidity.

Typical scenario

- Women are twice as likely to present with insomnia symptoms compared with men.
- Patient complains of often overwhelming daytime fatigue but rarely complain of sleepiness. However the difference between what is sleep and what is fatigue may have to be teased out from the patient.
- The patient is dissatisfied with the quantity and quality of her/ his sleep patterns.
- If the individual complains of daytime sleepiness then consider another sleep disorder such as obstructive sleep apnea, restless legs syndrome, periodic limb movements and depression.

Clinical Presentation

- Often present as being "wired & tired" (fatigued, but difficulty sleeping during day or night)

- May look fatigued with dark circles under the eyes but may equally look alert and normal.
- May appear anxious and exhibit some perfectionist tendencies.
- Not uncommon for the patient to state she/he is a "light sleeper" and very sensitive to any environmental noise.
- Normal range of body habitus –please note that post-menopausal women who are of normal BMI may be diagnosed with sleep maintenance insomnia when they may have undiagnosed OSA.

What to Ask

- How did the patient sleep as a child and teenager?
- What happened and when did the sleeping patterns change?
- What were the triggers or precipitating events?
- How do other members of the family and partner sleep?
- What is happening now in terms of sleep – time to bed, behaviours prior to bed, rituals (if any), reading, electronic media, effect of partner and his/her needs?
- Sleep Onset Latency (SOL) from turning out the light; How long is the patient sleeping before aware of waking; How long is the estimated wake time; What is the sleep time after that first wake; Does the patient stay in bed waiting for sleep or does she/he do something else such as getting up; What is the usual pattern after that; Is an alarm set in the morning and what is the usual getting up time?
- Weekends/holidays – is there a change in sleep patterns?
- Can the patient nap – when, where and for how long on average?
- Overall what is the estimated Time in Bed (TIB) and Total Sleep Time (TST). Work out Sleep Efficiency which is $TST/TIB \times 100/1$. Healthy sleep is generally 85% but following treatment for insomnia to achieve 80% is a good starting point.
- Ask re: caffeine, alcohol, exercise, eating at night, medications, over the counter medications and recreational drug use?

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- What does the patient do to “self-soothe” or what is her/his time-out time? How often does the patient actually do this?

Other Key Questions

- How often does the patient think about their sleep during the daytime?
- What thoughts is the patient aware of when getting ready for bed or even as darkness approaches?
- What thoughts is the patient aware of when she/he wakes in the middle of the night?

What to Examine

Check for possibility of other sleep disorders such as a narrow airway/ overweight as risk factors for OSA, peripheral neuropathy as risk factor for Restless Legs Syndrome and flat affect related to depression.

What investigations to order now/later

Ask the individual to complete the Insomnia Severity Index (ISI) (Bastien CH et al., 2001, Sleep Medicine; 4:297). This questionnaire can be administered and scored very quickly. Any score > 14 is diagnosed as clinical insomnia and any score > 22 is severe clinical insomnia. Scores from 7-14 are described as subclinical insomnia.

Treatment plan for today

Educate

Discuss normal sleep with emphasis on how most of our sleep is relatively light (45-55% of night light sleep, 20% deep sleep, 25% in dream/ REM sleep). Waking is also normal and it is what we learn to do with the wake and how we manage it which is most important. Sleep will not improve unless the individual starts to do something different.

What to do initially

- Highlight time currently being spent in bed much greater than perceived sleep time.
- Reduce time in bed slowly to increase sleep debt and improve sleep quality (ie sleep restriction protocol).
- Put in place a constant waking time regardless of previous night's sleep and combine with early morning light and exercise.
- Work with the patient to recognise symptoms of anxiety/depression and manage these.
- Assist patient to **Recognise, Acknowledge** and then **Do Something** (RAD approach) starting with simple measures.

Arrange

For patient to see a psychologist to re-learn better sleep practices using a cognitive behavioural therapy program for insomnia (CBT-I)

If difficulty accessing psychologist, can do online program (eg Sleepio or SHUT-I).

Emphasise the need to have many little strategies to do during the daytime if feeling anxious/stressed as sleep is a continuation of the day's events – it is NOT separate.

Future management

Advise the patient to return for a follow-up visit to assess whether more specialist care is required in relation to other sleep disorders or increasing anxiety, sleep anxiety or unremitting depression.

Where to access more information

Patient information:

www.sleephealthfoundation.org.au/pdfs/Insomnia.pdf

www.sleep.org.au/professional-resources/health-professionals-information/the-medical-journal-of-australia