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The Anxious Sleeper

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BOARD REVIEW CORNER

The patient is a 44-year-old married woman who reports a history of sleep-onset and sleep-maintenance insomnia that began following the birth of her now 5-year-old child. She denies excessive daytime sleepiness and denies breathing disruptions and witnessed apneas during sleep. She reports increased anxiety about her sleep across the years, with a notable exacerbation in the last year that appears to coincide with her child's first year of school. She describes her overall mood as "upbeat" and denies anxiety symptoms unrelated to sleep.

The patient states that she has "tried everything" for her sleep. She discontinued all caffeine use over 1 year ago; has minimized her alcohol intake, especially close to bedtime; and has been maintaining a regimented bedtime. Despite these practices, she reports often taking at least 60 to 90 minutes to fall asleep and reports prolonged awakenings about 3 nights per week. The patient did not complete sleep-diary records as requested but reports a rather consistent time into bed at 21:00, a range of rise times from bed (anywhere between 05:30 - 08:45), and an estimated total sleep time of 6 hours. She reports daytime fatigue and feeling that she cannot get as much done during the day as she used to. She describes feeling unable to relax in bed. She does not engage in activities in bed while awake because, as she states—she knows that it is not good for her sleep, and, in addition, she does not want to disrupt her husband's sleep. At these times, she describes her mind as often flooding with worry about why she is not asleep and reports thinking about uncompleted tasks from her day.

The patient has tried different medicines for her sleep, both over the counter and prescribed, but stopped with all sleep-medicine use about 6 months ago as she felt it had long been ineffective. The patient is not interested in further pursuit of pharmacologic treatment for her sleep at this time.

Of the following behavioral interventions, what would likely be the most effective recommendation for treatment of the patient's insomnia symptoms?

- a. Introduce patient to biofeedback training as it would help her to reduce physiologic arousal.
- b. Designate a fixed morning wake-up time of 06:00.
- c. Initiate sleep-restriction and stimulus-control techniques.
- d. Recommend outside psychotherapy to address underlying anxiety and worry.
- e. Initiate only sleep restriction. Stimulus-control techniques are not necessary because patient is not engaging in activities in bed.

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CORRECT ANSWER:
c. Initiate sleep-restriction and stimulus-control techniques.

This patient has a history and sleep pattern consistent with physiologic insomnia. The combination of sleep-restriction and stimulus-control techniques are therefore the most effective of the recommendations listed above. Clinical guidelines for the evaluation and management of chronic insomnia in adults support behavioral interventions as effective and recommended in the treatment of insomnia.[1] Stimulus control, which involves establishing a positive and clear association between the bed or bedroom and sleep, is regarded as a standard recommendation for the treatment of insomnia and may be particularly helpful in this case because the patient is spending extended periods of time in bed awake. Sleep restriction, which involves limiting time in bed to the amount of time one actually sleeps, intends to improve sleep continuity. It is regarded as a guideline behavioral intervention and, in practice, is generally combined with stimulus-control techniques. Biofeedback (answer a), although perhaps helpful in training the patient to reduce somatic arousal, is regarded as only a guideline for the treatment of insomnia and may not sufficiently target arousal at bedtime. Relaxation training, such as progressive muscle relaxation, is better documented in the literature and is often combined with behavioral techniques to lower somatic and cognitive arousal states interfering with sleep—but was not an option listed above. Designating a fixed morning wake time (answer b) may be a crucial component of enacting behavioral goals but will not be sufficient to elicit improvement. This intervention would still allow for too much time in bed awake, which is a known perpetuator of insomnia.

Pursuing outside psychotherapy (answer d) is a common recommendation made in a sleep clinic, but, here, it may not be the best option for specifically treating insomnia. When insomnia is clearly secondary to an anxiety disorder (which it is not in this case— the patient's anxiety is focused only on sleep), a recommendation of outside psychotherapy should be made. It is also helpful to note that the recommendation for outside psychotherapy is often offered in conjunction with behavioral recommendations that target insomnia. Initiating sleep restriction only without stimulus control (answer e) is incorrect. As mentioned previously, sleep restriction is generally combined with stimulus-control techniques and, in this case, should be no exception. Many individuals (such as this patient) often report not doing things in bed despite the fact that they are, in reality, spending extended periods of time in bed engaging in non–sleep-related activities, such as worrying, mental list making, and planning. Stimulus control is fundamental to helping this patient improve her sleep, and a combined effort to consolidate sleep is ideal and will likely be the most effective approach.

REFERENCE

1. Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M. Clinical guidelines for the evaluation and management of chronic insomnia in adults. *J Clin Sleep Med* 2008;4(5):487-504.

SUBMISSION & CORRESPONDENCE INFORMATION

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DISCLOSURE STATEMENT

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