

## EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

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## Breaking the Sleep Barrier

Kim A. Coon, Ed.D.

*Insomnia is a gross feeder. It will nourish itself on any kind of thinking, including thinking about not thinking.*

Clifton Fadiman (1904–1999)<sup>1</sup>

**I**t has been estimated that more than 50 million Americans experience some type of disorder of sleep. Despite this staggering statistic and the experts' declarations that sleep is vital to health and quality of life, sleep-disordered individuals rarely present with straightforward stories leading to accurate diagnosis and treatment.<sup>2</sup> It can sometimes be difficult to differentiate between fatigue and sleepiness. Insomnia is the most common sleep disorder diagnosis<sup>3</sup>; however, sleep may be influenced by a multitude of physical, environmental, and psychological factors.

Patients with insomnia are likely to display confounding psychological issues.<sup>4</sup> An inquiry about additional social and environmental factors may uncover stressful situations or life-changing events that contribute to the genesis or maintenance of sleep disturbance. Although life transitions are the most consistent feature of human existence, most life change is viewed as stressful. The level of stress experienced by the individual is influenced most by the appraisal of the change. The belief that the change will result in a loss or that the change event is uncontrollable appears to provoke the greatest stress and sleep disruption.

In primary care, treatment most often begins with the recommendation of medication. The last-resort treatment choice is reserved for referral to behavioral interventions. Current research findings, however, suggest that the order might properly be reversed. Providing sleep hygiene education, examining cognitions about sleep, enhancing circadian rhythms, and implementing environmental changes may all be significant components of a therapeutic program.

### CASE PRESENTATION

Mr. A was referred for treatment for "residual depressive symptoms" by his primary care physician. Despite overall mood improvement on an antidepressant drug, he continued to feel inordinate guilt, worthlessness, and fatigue. His initial therapy goals were to address self-esteem issues and to increase his energy for home and work activities.

The patient was a 38-year-old, married, white, male stock analyst with 1 child. He was a recent master of business administration graduate, a newlywed, and a recent father. He was first diagnosed with major depression in his early 20s and was treated off and on for 15 years with various antidepressants. While relating his history, Mr. A commented that he was a poor sleeper and that he had experienced chronic sleep problems since high school graduation. He had never told his internist about his sleep problem because he felt it was not a treatable problem. He tried prescription sedatives and over-the-counter sleep aids while in college, but he found that they produced daytime sleepiness, and he discontinued them.

New responsibilities at work were seen as pressures to perform and triggered fears that he was not up to the task. He felt overwhelmed and feared making mistakes, which contributed to bedtime ruminations. He experienced difficulty falling asleep and staying asleep, as well as early morning awakening. He worked nearly every evening on his laptop in bed, and he had 2 alcoholic drinks to unwind each evening. He left the television on each night to provide “background noise.” He attempted to make up for his weekday sleep deficits by staying in bed longer on weekends. He took lengthy naps on Sunday afternoons to prepare for the upcoming work week. He reported that his wife was unhappy with his work/sleep schedule because he did not help with household chores or with the baby.

At his second visit, I shared with Mr. A a conceptualization of his symptoms, stressors, and sleep problems. Mr. A was diagnosed with DSM-IV-TR recurrent, partial remission major depressive disorder and dyssomnia not otherwise specified. I suggested the early targeting of his sleep difficulty as a way to produce symptomatic improvement and better functioning. He expressed concern that his sleep patterns might worsen if he departed from his current routine. I reassured him that we would begin with the collection of sleep information and that no changes in his sleep patterns would be recommended until we both understood the scope of the problem.

## PSYCHOTHERAPY

Mr. A’s initial home practice assignment was to gather sleep/wake information for 1 week in a sleep diary. When he produced it, the diary reflected a weekly average of 4.5 hours of sleep per night. He went to bed at around 8 p.m. and got out of bed at 6 a.m. most weekdays. His sleep efficiency (total sleep time/time in bed  $\times$  100) was 45%. (Ideal sleep efficiency is above 90%.) This discrepancy suggested that even small increases in efficiency might result in improved energy and well-being. We examined the meaning of his spending more time with his wife and child. We noted that mood disorders contribute to sleep difficulties and sleep disorders worsen depression as well. As a home practice experiment, Mr. A agreed to decrease his alcohol intake at bedtime, to get out of bed when he could not get back to sleep in 30 minutes, and to try to get up at the same time each morning.

At our next session, Mr. A reported that he missed his bedtime nightcaps but felt that his sleep was more restful without them. When he decided to use some time gained to give his baby her first bottle of the day, he found that he enjoyed the time with his daughter and that his wife appreciated the time to rest. We discussed some recent research on the treatment of insomnia and applied it to his situation. I recommended that he modify his sleep environment and match his time in bed with his average nightly sleep time. He worried that he might become even more fatigued if he limited his sleep to just 4.5 hours per night. I reminded him of how long he had suffered with insomnia and invited him to consider that any temporary discomfort might enhance his overall quality of life. We examined his thoughts about time in bed and challenged his concerns with evidence from his sleep diary.

For stimulus control, Mr. A agreed to remove all electrical appliances and devices from his bedroom, and to use his bed for sleep or sex only. Sleep restriction protocols suggest that patients keep their desired awakening time, so Mr. A continued to get out of bed at 6 a.m. We then pushed his bedtime up to 1:30 a.m. He was uncertain whether he could stay awake this late, and his concerns were disputed, once again, using his sleep diary.

Although Mr. A had some initial difficulty with sleep restriction techniques, he followed them faithfully. He eventually increased his average sleep time to 6.5 hours per night and achieved a sleep efficiency of 80%. He felt that this was a great improvement, and his wife was very happy with his behavioral changes, reporting that he was more engaged in family activities and that he seemed more content with his lifestyle. By the end of 10 sessions of therapy, Mr. A reported that his fatigue symptoms were resolved. He found, too, that his mood and self-esteem improved as his sleep normalized.

## REFERENCES

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