

# “I Can’t Sleep”

By Tabarak Qureshi, MD



## INSOMNIA

Insomnia is defined by a repeated difficulty with sleep initiation, duration or quality of sleep (despite adequate time and opportunity to sleep), resulting in daytime impairment. In adults, insomnia complaints are related to difficulties in initiating and maintaining sleep. Concerns about extended periods of nocturnal wakefulness or insufficient amount of nocturnal sleep accompany these complaints. In children, insomnia is usually reported by parents and characterized by bedtime resistance, inability to sleep or both.

In milder cases, daytime symptoms may include fatigue, irritability, decreased mood, general malaise and cognitive impairment. Chronic insomnia in adults may impair social and vocational functioning and reduce quality of life. In children it may lead to poor school performances. Physical symptoms may include headaches, muscle tension and gastrointestinal complaints. Insomnia is a symptom that may arise from primary medical illnesses, substance use and or abuse, other sleep and mental disorders.

Definition of a sleep wake disturbance in a patient with insomnia is a complex task since it may be multifactorial and frequently there may be a confluence of factors that may result in insomnia.

### ACUTE INSOMNIA: (ADJUSTMENT INSOMNIA)

The essential feature of acute insomnia is associated with an identifiable stressor. The sleep disturbance is usually of short duration, typically a few days to weeks. Adjustment insomnia is acute in onset and lasts no more than three months. The sleep disturbance is expected to resolve when the specific stressor resolves or the individual adapts to that stressor. Stressors that have been identified include interpersonal relationships, occupational stress, bereavement, diagnosis of a medical condition, personal losses, visiting or relocation to a new location. Change or stress with an emotional tone may precipitate acute insomnia. Individuals with a prior history of insomnia are predisposed to developing further episodes. Polysomnographic findings may include prolonged sleep latency, increased number and frequency of awakenings, short overall sleep time and reduced sleep efficiency. Latency to REM sleep is prolonged and percentages of stages N3 and REM reduced.

### PSYCHOPHYSIOLOGICAL INSOMNIA (CHRONIC INSOMNIA, PRIMARY INSOMNIA)

Features of psychophysiological insomnia includes heightened arousal and learned sleep preventing associations that result in a complaint of insomnia and decreased functioning during wakeful periods. The physiological arousal may be related to emotional reactions that do not meet criteria for separate disorders. Mental arousal with a typical complaint of a “racing mind” is characteristic. A cycle develops in which the more the individual strives to

sleep, the more agitated one becomes and the less able one is to fall asleep. Persons with a conditional arousal response typically sleep better away from their own bed and usual routines. Stress symptoms, environmental factors, and life changes are often associated with precipitating psychophysiological insomnia. Polysomnographic findings will show increased sleep latency, or increased wake after sleep onset, increased N1 and decreased slow wave sleep

### PARADOXICAL INSOMNIA: (SLEEP STATE MISPERCEPTION, PSEUDO-INSOMNIA)

Paradoxical insomnia is a complaint of severe insomnia that occurs without evidence of objective sleep disturbance and without the level of daytime impairment associated with the degree of sleep deficits reported. The complaint of decreased sleep time or no sleep is accompanied with extensive awareness of either the environment or mental processes consistent with wakefulness. Like other patients with insomnia, paradoxical insomnia is reported with daytime symptoms related to sleep complaints. The severity of nocturnal complaints are not matched by evidence of pathological sleepiness, marked performance decrements and other functional impairments during the day that may result from marked sleep deprivation. This condition is found in less than 5 % of population. It is more common in young and middle aged adults (with a preponderance in women). Polysomnographic findings fail to show sleep deficits and standard sleep parameters are similar to those of individual without sleep complaints.

### INSOMNIA DUE TO MENTAL DISORDER (PSYCHIATRIC INSOMNIA)

Essential feature is insomnia caused by underlying psychiatric or mental disorder. The insomnia is viewed as a symptom of the underlying mental disorder and shares a course with that disorder, however the insomnia constitutes a distinct complaint and focus of treatment. In some cases the underlying mental disorder may become more apparent only after specific questioning. Mood and anxiety disorders may underlie this insomnia. It affects less than 3% of the population, mostly young to middle aged adults and is more common in women. Polysomnographic findings include increased sleep latency with decreased sleep efficiency, increased N1 and N2 sleep with decreased N3 and REM sleep.

### INSOMNIA DUE TO DRUG OR SUBSTANCE USE (SUBSTANCE INDUCED SLEEP DISORDER)

Insomnia due to substance or drug use is a suppression or disruption of sleep caused by consumption of a prescription medication, recreational drug, caffeine, alcohol or food item. Sleep disturbance may result from substances that act as CNS stimulants or depressants. Stimulants that commonly lead to sleep difficulty include caffeine, amphetamines and cocaine. Side effects of pre-

scription medications (including certain antidepressants, antihypertensive medications, corticosteroids, antiparkinsonian drugs, etc) can lead to insomnia. Alcohol is commonly used as a sleep aid, however it can actually lead to restless and fragmented sleep. Polysomnographic findings include increased sleep latency and arousals with decreased total sleep time and reduced REM sleep.

### INSOMNIA DUE TO MEDICAL CONDITIONS:

Insomnia caused by a coexisting medical condition may involve sleep initiation or maintenance, or over all poor quality of sleep. Obstructive lung disease may be characterized by difficulty initiating sleep, fragmented sleep associated with respiratory distress. Several neurological disorders any cause insomnia because they lead to fragmented sleep patterns, subjective sleep concerns and disruption of sleep wake cycles. The insomnia usually begins near the time of onset or with significant progression of the underlying disorder and waxes and wanes with fluctuation with the disorder. No significant polysomnographic findings occur in this type of insomnia.

### BEHAVIORAL INSOMNIA OF CHILDHOOD: (CHILDHOOD INSOMNIA)

The essential feature is difficulty falling asleep, staying asleep or both that is related to an identified behavioral etiology. Sleep onset association type is characterized by child's dependence on specific stimulation, objects or settings for initiating sleep or returning to sleep after awakening. This may be associated with daytime behavioral problems, limit setting difficulties in the day, or both. It occurs in 10-30% of the childhood population. In addition, this leads to poor parental nighttime sleep and associated daytime impairment. Developmental issues like childhood milestones and separation anxiety may predispose a child to develop sleep problems.

### SLEEP ONSET ASSOCIATION TYPE:

A type of behavioral insomnia that is characterized by reliance on inappropriate sleep associations, and usually presents with frequent nighttime awakenings. In this disorder, the process of falling asleep is associated with a specific form of stimulation (rocking or watching television, etc), object (bottle) or setting (specific room, bed). As this disorder is prevalent in younger children, it is defined as a disorder only if the associations are problematic (long car rides).

### LIMITED SETTING TYPE:

This involves refusing or stalling to go to sleep. If sleep is enforced it comes quickly, otherwise onset is delayed. The bedtime problems usually occur as parents do not set specific bed time, limits and managing behavior. However normal and prolonged separation anxiety may trigger behavioral insomnia in children.

### TREATMENT

Treatment for insomnia is multifaceted. A thorough evaluation with sleep history is the corner stone. Sleep hygiene measures, Behavioral treatment (stimulus control, sleep restriction, progressive muscle relaxation, etc) and pharmacological therapy (sedative hypnotics, etc) are ways by which there can be improvement in sleep times and in turn functional capacity of the patient.

*Tabarak Qureshi, MD, graduated from Baqai University Medical School in 2000. He then completed an Internal Medicine Residency as well as a Pulmonary/Critical Care Fellowship at Detroit Medical Center (Wayne State University) in Detroit, Michigan. Dr. Qureshi then went on to complete a Sleep Medicine Fellowship at Detroit Receiving Hospital (Wayne State University) in Detroit, Michigan. Since 2009, he has been a member of the Central Florida Pulmonary Group. Currently he serves as the Sleep Lab Medical Director for Physician Associates of Florida and as an Assistant Professor for the University of Central Florida School of Medicine.*

*Dr. Qureshi may be contacted at 407-841-1100 or by visiting [www.cfpulmonary.com](http://www.cfpulmonary.com). ■*

MICHAEL R. LOWE, P.A.

DEDICATED TO HEALTH CARE LAW.

Focused on Physicians.

Michael R. Lowe, Esq.

Board Certified Health Law Attorney



2180 West S.R. 434, Suite 1124  
Longwood, Florida, 32779

407-332-6353 • [mlowe@lowehealthlaw.com](mailto:mlowe@lowehealthlaw.com)

The hiring of an attorney is a decision that should not be based solely on advertisements. Before you decide, ask us to send you free written information about our qualifications and experience.