

How to cope with insomnia

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Why read this?

Almost all of us have experienced short-term sleep disturbance – occasional nights where we take longer than we would like to fall asleep, spend long periods of time awake up during the night, or waking up too early in the morning. When we experience an upsetting event, such as a death in family or experience anxiety and uncertainty during challenging periods such as the Covid-19 pandemic, it is common for sleep disturbance to become more severe. When the event has passed, our sleep will typically return to normal. However, in some situations, sleep disturbance remains for the long-term, and we develop insomnia. Reading this information sheet will help you to understand what insomnia is, how it develops, and how it can be treated.

What is insomnia?

Insomnia is a sleep disorder that combines dissatisfaction with sleep, with a significant negative impact on daytime functioning.¹ Dissatisfaction with sleep is further defined as difficulty initiating and/or maintaining sleep, or non-restorative sleep, on at least three nights per week for at least three months, despite adequate opportunity to sleep. Negative impacts on daytime functioning can include fatigue, sleepiness, poor concentration, low mood, or impaired ability to perform social, occupational or care-giving responsibilities. Insomnia symptoms are also linked with considerable financial impact such as loss of productivity, absenteeism, and health care costs.²

How does insomnia develop?

The '3 Ps' model is useful in understanding how an episode of disturbed sleep can sometimes become embedded, then develop into insomnia (Figure 1).³

The model proposes that we all have an 'insomnia threshold' that can be exceeded by a combination of the '3 Ps': predisposing,

precipitating, and perpetuating factors.

Identifying your unique '3 Ps', that is, your own predisposing, precipitating and perpetuating factors for insomnia, is fundamental to effective treatment. Recognising the specific triggers, and seeking professional help in the short-term (see section below on how to do this), will help prevent the development of chronic insomnia.

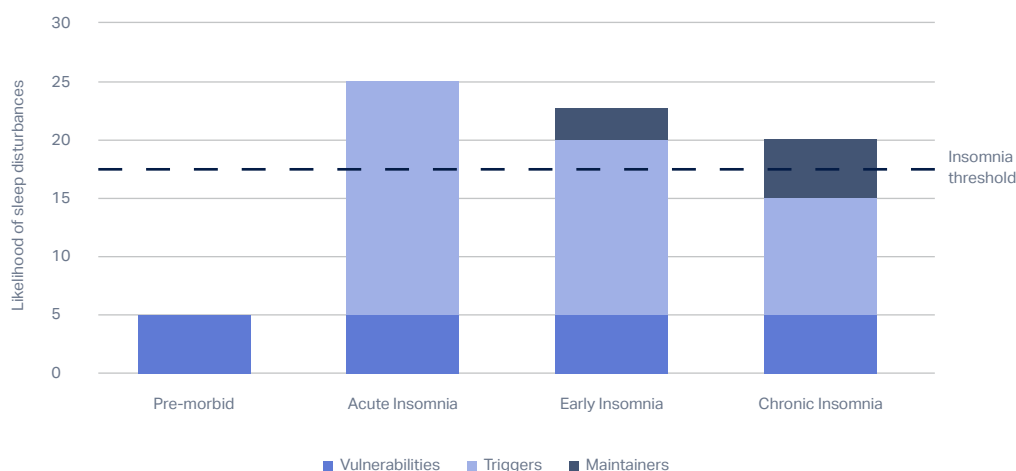


Figure 1. The '3 Ps' model of how insomnia develops.³ Acute insomnia: not sleeping well when you experience a difficult/stressful event; Early insomnia: short-term insomnia; Chronic insomnia: long-term insomnia.

Predisposing factors – vulnerabilities

The predisposing factors listed below increase our vulnerability, or likelihood of reaching the threshold for insomnia:

- a family history of insomnia
- being a woman
- being older
- being a worrier, or a perfectionist
- being excitable, or having difficulty in switching off
- a history of shift work.

Precipitating factors – triggers

The precipitating factors or triggers for developing insomnia include:

- becoming ill
- major life events such as a new baby, splitting up with your partner, or bereavement.

In response to these events, it is normal to experience short-term sleep disturbance; however, if we continue to be stuck in a pattern of worrying about sleep, this can lead to insomnia.

Perpetuating factors – maintainers

After the triggering event has passed, perpetuating factors maintain insomnia, and act as barriers to recovery. Examples of perpetuating factors include:

- having a combination of depression and insomnia
- a tendency to ruminate, which is repetitively thinking sad or dark thoughts, usually about the same topic or scenario, such as an upsetting event.

Chronic insomnia: the 'coping behaviours' that don't work

Over months and years, individuals with insomnia usually also learn and practise a range of coping behaviours that they think help them to cope with insomnia; however, these habits and routines are often not helpful, but instead maintain insomnia in the long-term. Some of the coping behaviours that maintain insomnia are:

- Spending extra time in bed in an attempt to compensate for lost sleep. Because much of this extra time is spent lying awake, it diminishes the association between bed as the place where sleep occurs.
- Distracting a 'racing mind' by playing video games, and using tablets and phones, which inadvertently makes us more alert.
- Avoiding social activities in the evening for fear of disrupting sleep. This can increase feelings of isolation and anxiety about sleep.
- Napping during the afternoon to cope with sleepiness and fatigue. This makes it difficult to sleep at night.

When we adopt behaviours that worsen insomnia, we also tend to worry about sleep itself and the consequences of not sleeping, for example, worrying about how little sleep we are going to get, and how tired and miserable we are going to feel tomorrow. This sort of thinking can develop into 'catastrophising', where we think that the sleep difficulties we are experiencing are permanent, the negative effects of not sleeping are permanent, and that we will become ill. We may experience intrusive thoughts and physical sensations such as panic-like emotions, which in turn further promote anxiety and insomnia.

The role of unrealistic expectations

The link between poor sleep and poor function and distress is not straightforward. Not all individuals who have disturbed sleep say that they identify themselves as having insomnia or struggle with alertness during the day. Conversely, some individuals who sleep well, identify themselves as having insomnia, and show high levels of fatigue, anxiety and depression similar to patients who suffer from other sleep disorders. It seems that some people who identify themselves as having insomnia have developed unrealistic expectations about what constitutes good sleep. For example, taking longer than 15 minutes to fall asleep, or one night of poor sleep, might be perceived as an insomnia issue if an individual focuses on the possible negative consequences of disrupted sleep.

Individuals with insomnia might have unrealistic beliefs about how long they need to sleep to feel at their best. For example, they might believe that we must obtain eight hours of sleep, and older people might expect to sleep for as long as they did when they were younger. The reality is that the amount of sleep we need varies between individuals, and sleep changes with age. Sleep disturbance should not be permanent.

I think I may have insomnia. What should I do next?

If you are concerned you, or someone you know, may have insomnia, you should seek professional help without delay. Insomnia is not something you should 'just put up with' and it can be successfully treated. As insomnia is a major risk factor for depression, treating insomnia will reduce the likelihood you will develop a mental health problem later on. If you are struggling with depression you are likely to sleep too little or too much. Sleeping better will improve your sleep problem and mental health.

What is the treatment for insomnia?

1. Cognitive-Behavioural Therapy for Insomnia (CBT-I)

As what we think and how we behave plays a major role in insomnia, CBT-I is the first-line treatment for insomnia CBT-I addresses both the cognitive (e.g. thoughts and beliefs) factors and behaviours (e.g. habits and routines) that contribute to insomnia (Figure 2). Following CBT-I treatment, 70–80% of people with insomnia report significant improvements in sleep quality, and 40–60% of people maintain the positive benefits in the long-term. CBT-I has had a positive impact on wellbeing by reducing sleepiness, fatigue, and increased quality of life.

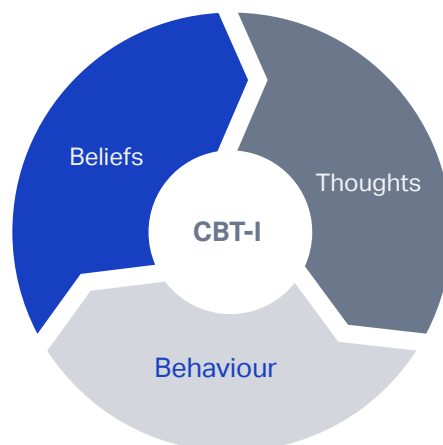


Figure 2. The vicious circle of insomnia and the role for CBT-I

CBT-I can be delivered in-person by a clinician trained in CBT-I. Alternatively, it can be delivered digitally using validated web-based or mobile apps.⁴ Individual CBT-I treatment plans vary in content and length, but typically four to eight hours of therapy are necessary over a period of six to eight weekly sessions. Over this period, people learn positive cognitive and behavioural techniques to improve sleep, and keep a diary of their sleep to monitor changes. Behavioural techniques include the following sleep rescheduling and stimulus control strategies.

Sleep rescheduling (sleep restriction) involves:

- Limiting the time you spend in bed to just the time that you should be sleeping. This seems counterintuitive and initially causes sleep deprivation, but by reducing the opportunity to lie awake in bed, it can restore your normal healthy sleep pattern of sleep-wake.
- No daytime napping.
- Waking up at the same time every day, including during the weekend.

Sleep restriction works by increasing sleep pressure and restoring the homeostatic sleep drive, one of the body mechanisms that regulates sleep. According to a recent review, sleep restriction remains the most successful component of CBT-I for reducing insomnia in the long-term.⁵ It is important to note that sleep restriction should be carried out under the supervision of a clinician who will consider the impact on your ability to drive and/or work.

The stimulus control techniques described below aim to break the negative associations between the bed, bedtime routine, and sleeplessness:

- Only go to bed when you are very sleepy.
- Use the bed and bedroom only for sleeping and sex, not reading, watching TV, or using your phone.
- If you are awake for more than 20 minutes, get up and leave the bedroom to read a book in dim light, or to meditate.
- If you are in a hotel room, if possible, try to not use the bed at all during the day, and reserve the bed for night-time sleep. If you wake up during the night and have difficulty getting back to sleep, get out of bed and sit in a chair.
- Try not to sleep sitting up or in a recliner as our sleep quality is best when lying flat.

Cognitive techniques for treating insomnia aim to reduce rumination and catastrophising. One technique that is growing in popularity is mindfulness. Mindfulness is centred on the idea that noticing your thoughts, but without judgement, reduces anxiety. In the case of insomnia, mindfulness teaches you to accept that you have insomnia by describing what it is like (e.g. lying awake feeling your heart pumping) without a negative evaluation (e.g. 'I will have a heart attack'). Some people do not take up mindfulness because it requires time and patience to achieve results, but if you can stick with it, mindfulness combined with behavioural strategies can be an effective treatment for insomnia.⁶

2. What about sleeping pills?

If you are suffering from an acute bout of insomnia as a result of a stressful period, your doctor may have prescribed sleeping pills. If taken for a short period of time, sleeping pills can be a way of immediately getting some sleep. However, the sleep induced by sleeping pills has a different architecture to natural sleep, and is more akin to being sedated. After taking a sleeping pill, your sleep isn't as restorative and, although you will have slept, you will feel drowsy the next day.

More importantly, medication does not treat the cause of a sleep problem, but only the symptom so in the long run non-drug treatments, such as CBT-I are preferable.

That said, a combination of techniques including medication may be used by your doctor if initial non-drug therapies are not effective at dealing with a sleep disorder.⁷ It is therefore important that you speak to your doctor about long-term viable treatment options.

To summarise

The way we think can affect the way we behave, and result in the development of insomnia. Changing unhelpful beliefs and routines has a positive effect on insomnia. If you believe that you have sleep difficulties or suffer from insomnia, you should seek expert help.

What should I read next?

The following may be of interest:

- What are the body mechanisms that regulate sleep?
- How to adjust my beliefs and thoughts about sleep
- How to seek professional support to improve chronic sleep difficulties
- How sleep changes as we get older: for adults 26-64 years old
- How to improve sleep in adults aged 65 or older

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