THE DEFINITION OF INSOMNIA

I KNOW IT WHEN I SEE IT

I KNOW IT WHEN
I HEAR ABOUT IT ?

**“Until you've experienced it yourself,
it may seem contradictory that a person can be
utterly exhausted and yet unable to sleep,
but that's precisely [it]…”**

www.health.com/health/condition-article/0,,20188079,00.html

DEFINITION - ETYMOLOGY

Word Origin & History

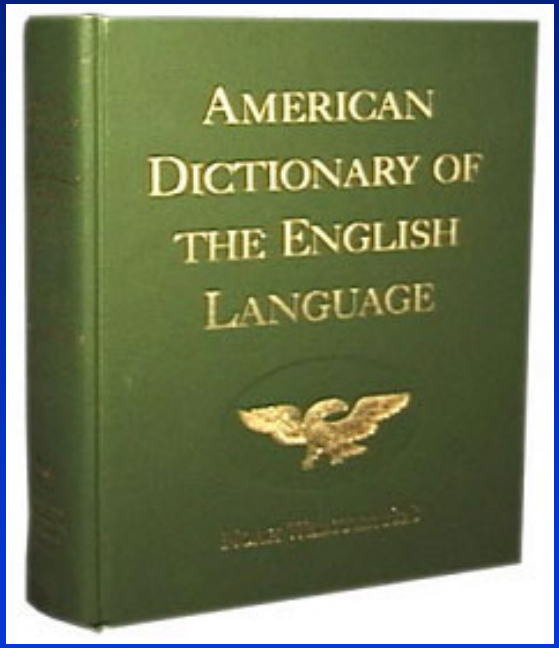
insomnia

1623, Anglicized as insomnie, from L. insomnia "want of sleep," from in- "not" + somnus "sleep" (see somnolence). The modern form is from 1758. Insomniac (n.) is from 1908.

Cite This Source

http://dictionary.reference.com/browse/insomnia

DEFINITION - COMMON DICTIONARY



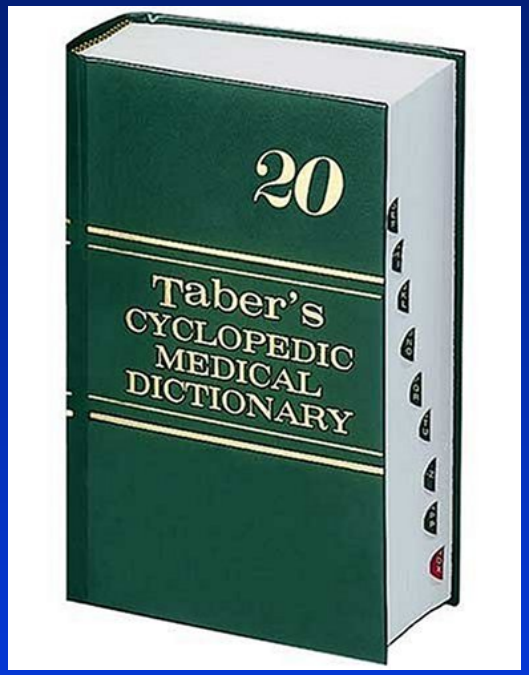
Dictionary

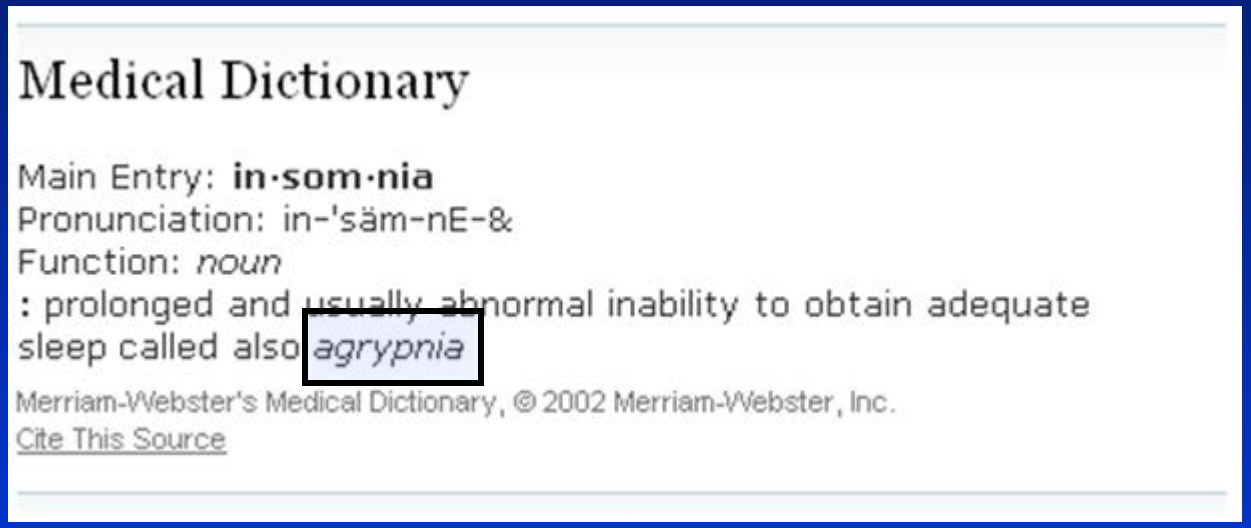
insomnia [(in-som-nee-uh)]

A persistent and prolonged inability to sleep.

http://dictionary.reference.com/browse/insomnia

DEFINITION - MEDICAL DICTIONARY





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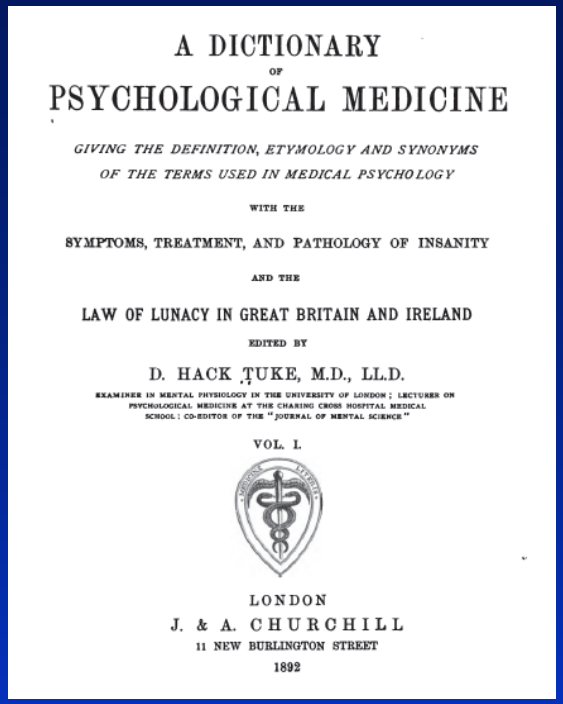

A DICTIONARY
OF
PSYCHOLOGICAL MEDICINE

GIVING THE DEFINITION, ETYMOLOGY AND SYNONYMS OF THE TERMS USED IN MEDICAL PSYCHOLOGY

WITH THE

SYMPTOMS, TREATMENT, AND PATHOLOGY OF INSANITY

AND THE

LAW OF LUNACY IN GREAT BRITAIN AND IRELAND

EDITED BY

D. HACK TUKE, M.D., LL.D.

EXAMINER IN MENTAL PHYSIOLOGY IN THE UNIVERSITY OF LONDON; LECTURER ON PSYCHOLOGICAL MEDICINE AT THE CHARING CROSS HOSPITAL MEDICAL SCHOOL; CO-EDITOR OF THE "JOURNAL OF MENTAL SCIENCE"

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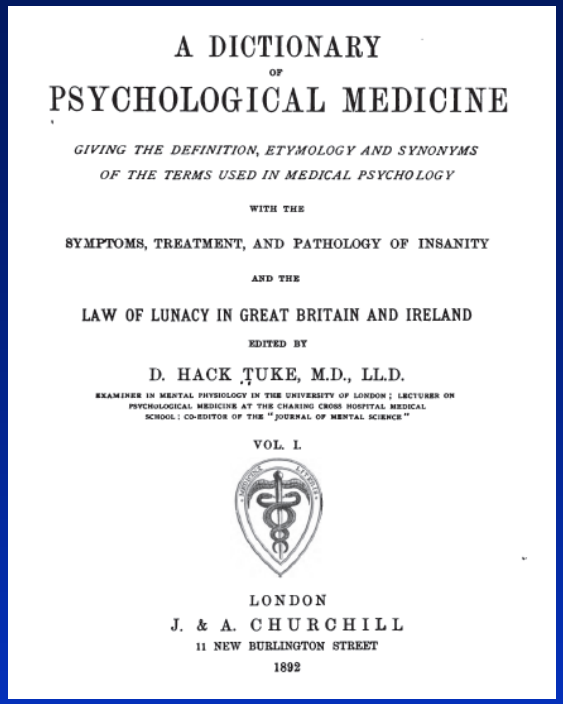
11 NEW BURLINGTON STREET
1892

A Dictionary of Psychological Medicine
Ed. D. Hack Tuke MD LLD, JA Churchill, London
1892. Vol. 1 p. 61.

AGRYPNIA (*ἄγρυος*, wild or restless; *ὕπνος*, sleep). A term for wakefulness or sleeplessness; one of the premonitory symptoms of various forms of insanity. (Fr. *agrypnie*; Ger. *Schlaflosigkeit*).



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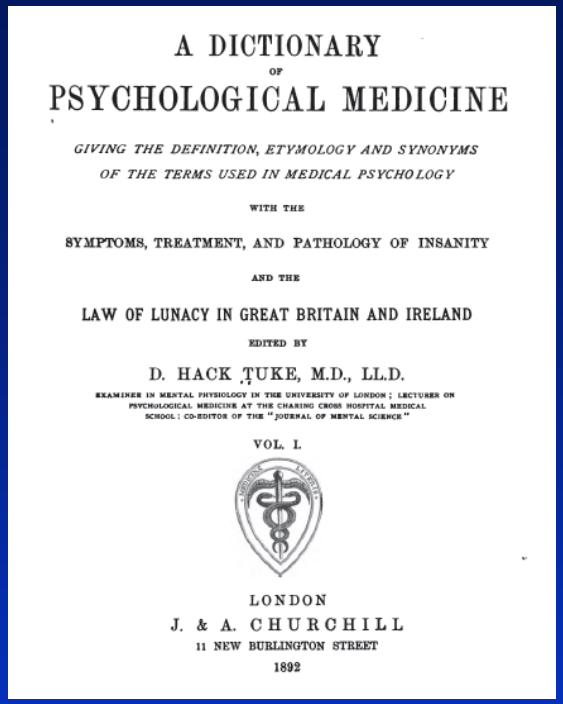
AGRYPNIA PERTŒSA (*ἄγρυος*; *ὕπνος*; *pertoesus*, disturbed). Sleeplessness from bodily disquiet, with attention alive to surrounding objects.



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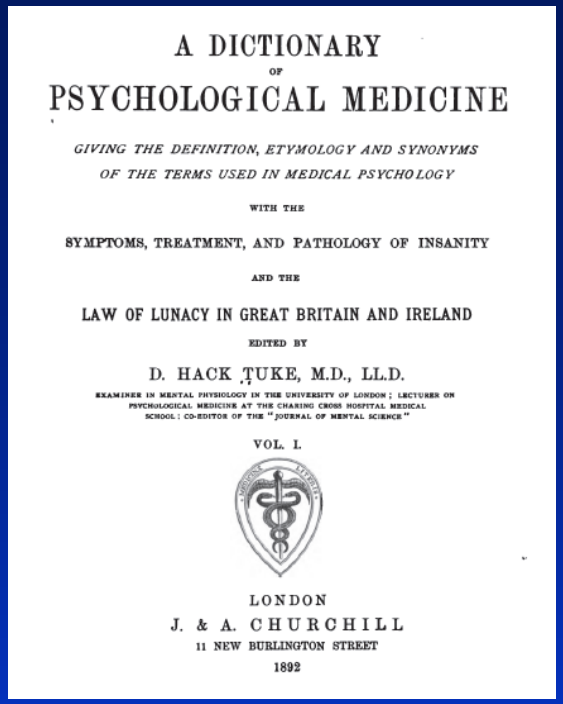
AGRYPNIA EXCITATA (ἄγρυπνος; ὕπνος; *excito*, I stir up). Sleeplessness due to mental excitement with listlessness as to surrounding objects.



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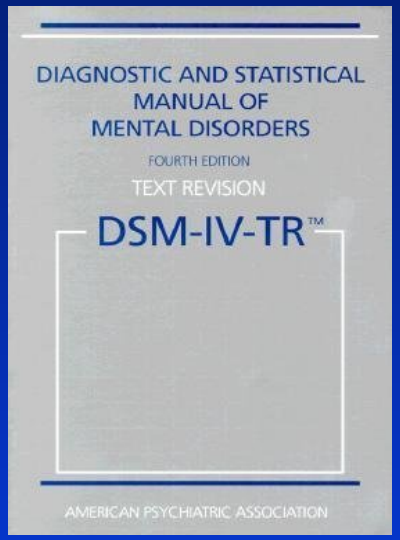
1892. Vol. 1 p. 61.

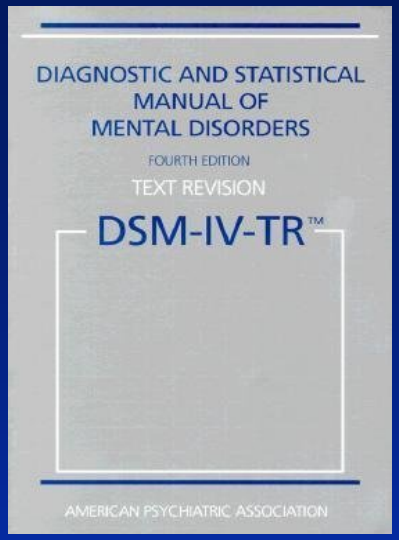
AGRYPNIA SENILIS (ἀγρυπνος; ὕπνος; *senilis*, pertaining to old age). The sleeplessness of old age.

CLASSIC DEFINITIONS

CLASSIC DEFINITIONS



GENERAL CONCEPTUALIZATIONS



PRIMARY INSOMNIA

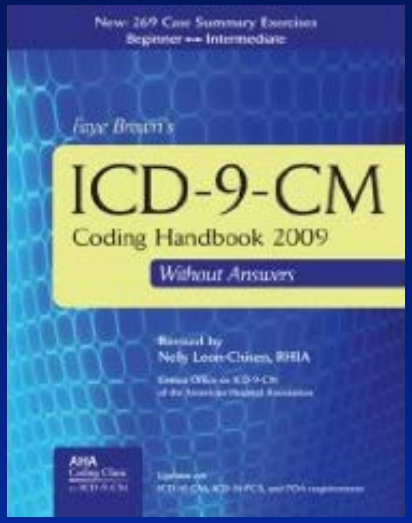
A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month.

B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The sleep disturbance does not occur exclusively during the course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parasomnia.

D. The disturbance does not occur exclusively during the course of another mental disorder (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, a delirium).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.



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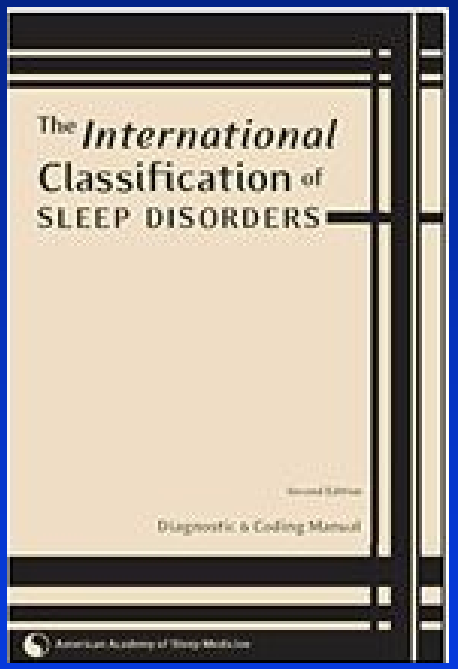
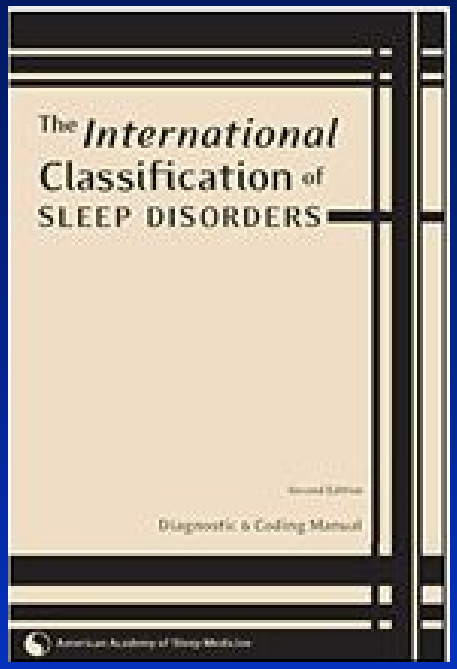
SPECIFIC CONCEPTUALIZATIONS





MORE THAN ONE FORM OF PRIMARY INSOMNIA

IDIOPATHIC INSOMNIA

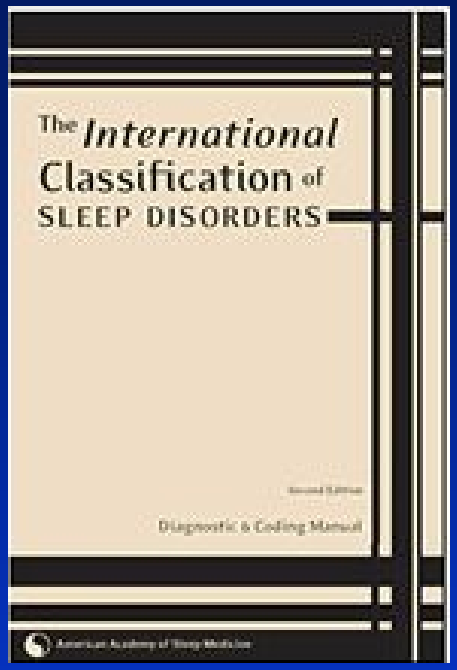
PSYCHOPHYSIOLOGIC INSOMNIA

PARADOXICAL INSOMNIA

INADEQUATE SLEEP HYGIENE INSOMNIA

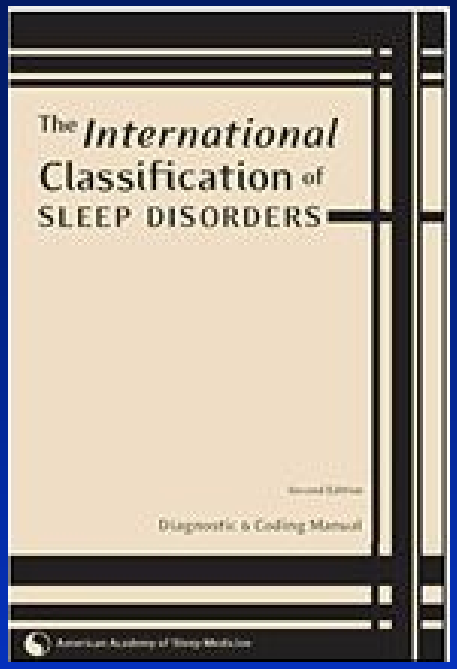
PHYSIOLOGICAL INSOMNIA

INSOMNIA NOS



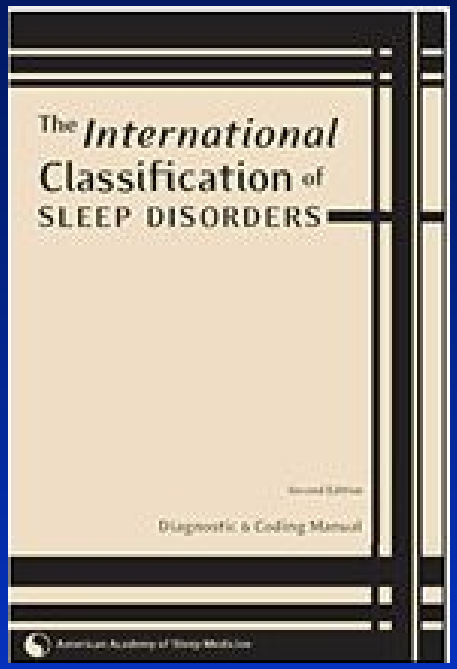
IDIOPATHIC INSOMNIA

LIFELONG INSOMNIA WITH A PRESUMED ORGANIC COMPONENT



PSYCHOPHYSIOLOGIC INSOMNIA

A FORM OF INSOMNIA THAT IS CONCEPTUALIZED AS BEING PERPETUATED BY BOTH PSYCHOLOGICAL (BEHAVIORAL AND COGNITIVE) AND PHYSIOLOGICAL FACTORS



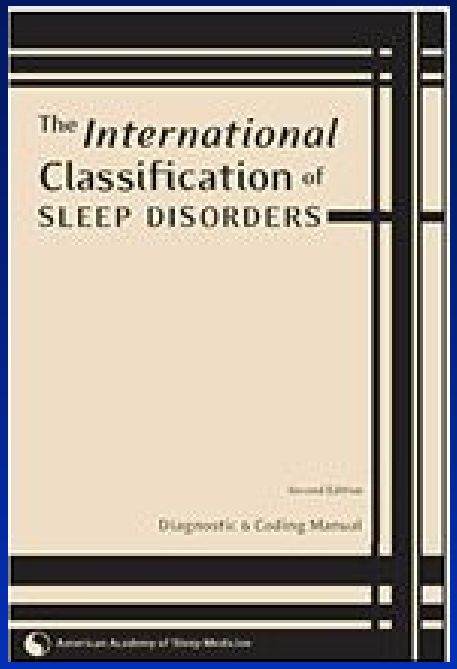
PSYCHOPHYSIOLOGIC INSOMNIA

THE FORMAL DEFINITION

THE PATIENT HAS EVIDENCE OF CONDITIONED SLEEP DIFFICULTY AND/OR HEIGHTENED AROUSAL AT SLEEP ONSET AS INDICATED BY

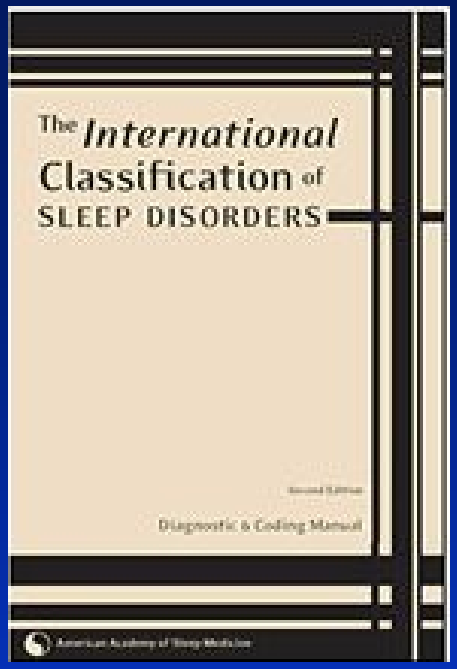
- **EXCESSIVE FOCUS ON, AND ANXIETY ABOUT, SLEEP**
- **SLEEP MAY OCCUR IN NOVEL PLACES, TIMES, ETC.**
  (I.E., IN THE ABSENCE OF CONDITIONED STIMULI)
- **MENTAL AROUSAL OCCURS AS INTRUSIVE THOUGHTS OR INVOLUNTARY RUMINATION**
- **SOMATIC AROUSAL - FEELING PHYSICALLY "WOUND UP"**

THERE IS EVIDENCE OF "SLEEP EXTENSION" (EXPANDED SLEEP OPP & LOW SE%)



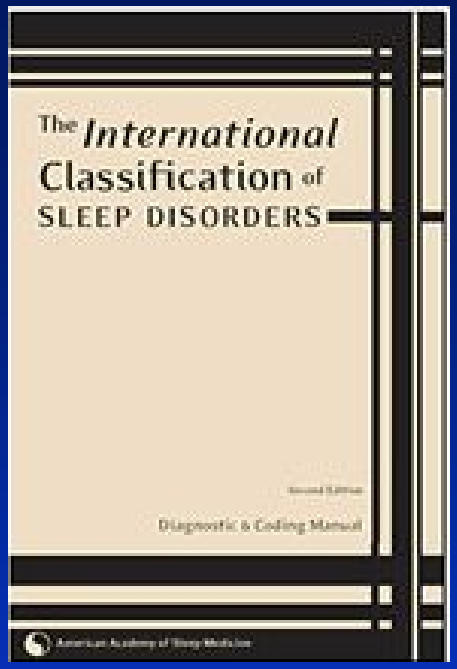
PARADOXICAL INSOMNIA

A FORM OF INSOMNIA FOR WHICH THERE IS A PROFOUND DISCREPANCY BETWEEN THE PATIENT'S EXPERIENCE OF SLEEP CONTINUITY DISTURBANCE AND THE MEASURE OF INSOMNIA SEVERITY BY POLYSOMNOGRAPHY



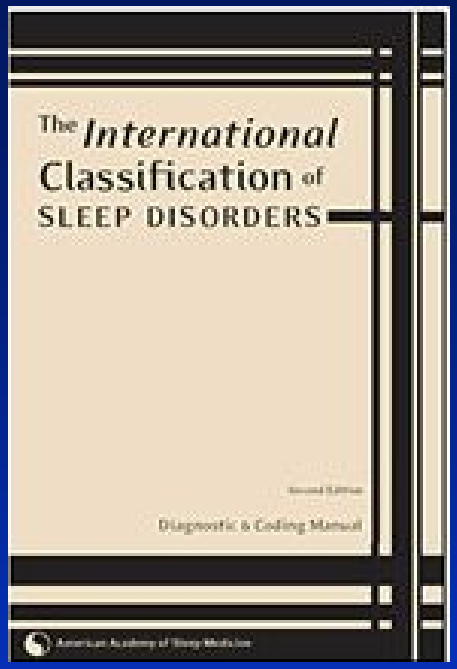
INADEQUATE SLEEP HYGIENE INSOMNIA

A FORM OF INSOMNIA THAT IS CONCEPTUALIZED AS BEING PERPETUATED, IN LARGE MEASURE, BY LIFESTYLE ISSUES



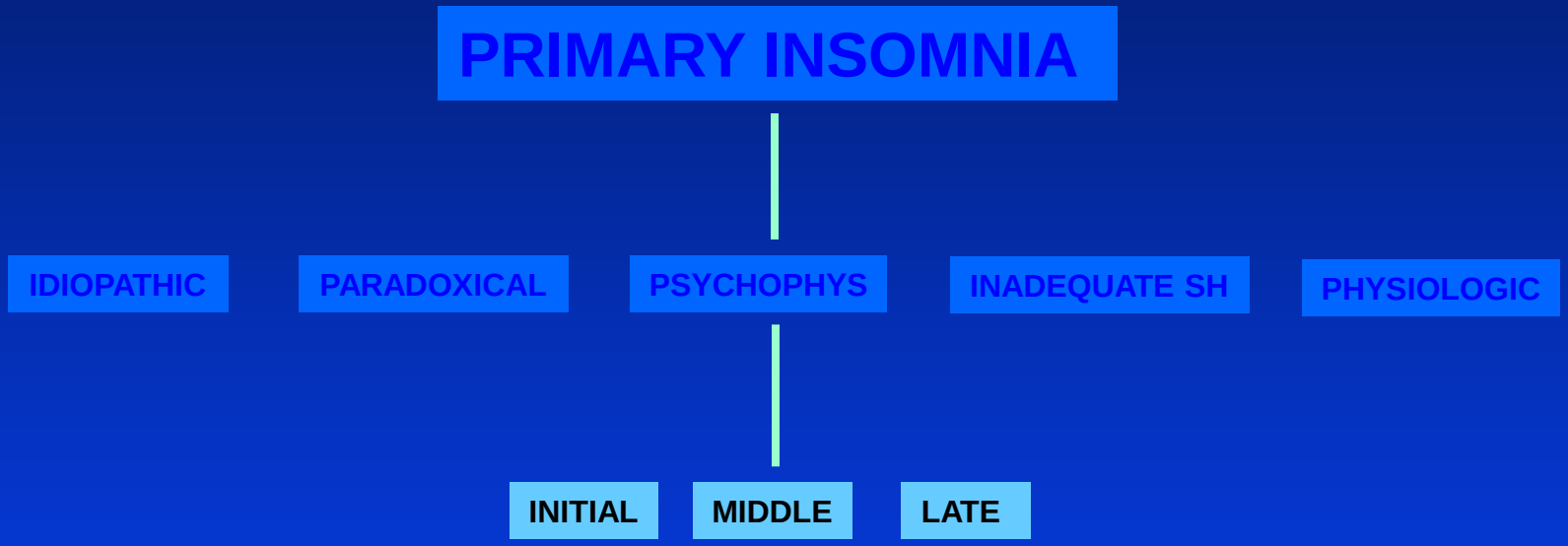
PHYSIOLOGICAL INSOMNIA

A FORM OF INSOMNIA THAT IS CONCEPTUALIZED AS BEING PERPETUATED, IN LARGE MEASURE, BY ORGANIC FACTORS

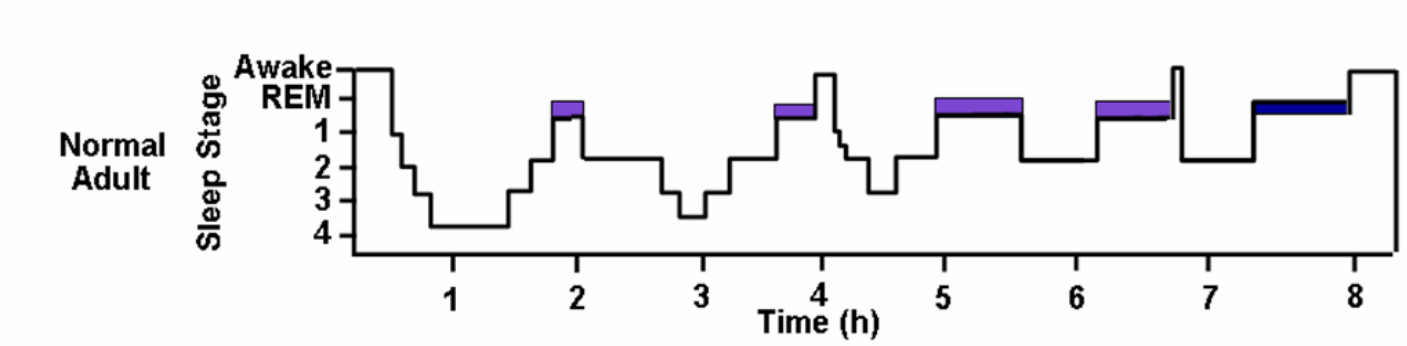


INSOMNIA NOS

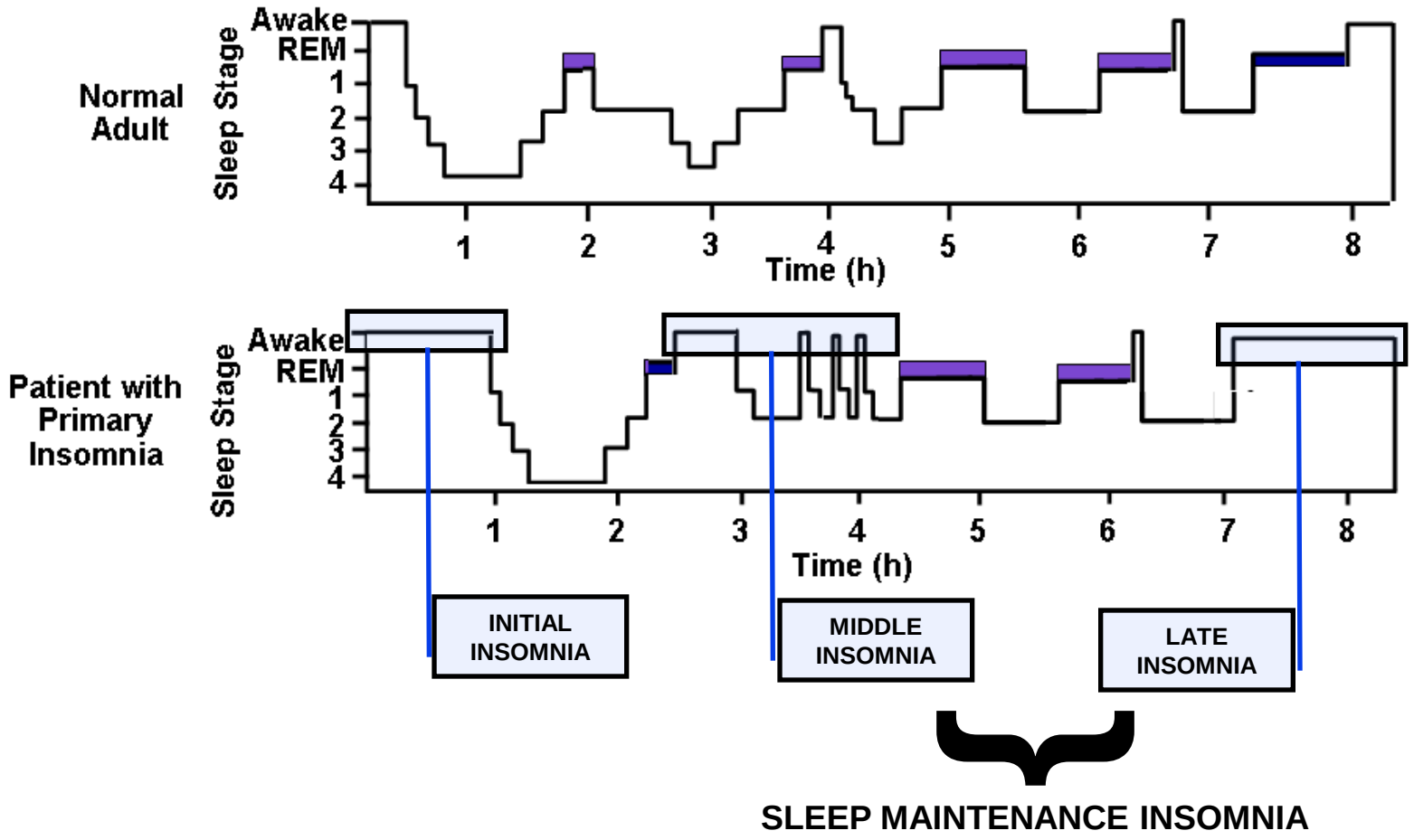
ARE THERE SUBTYPES OF INSOMNIA?



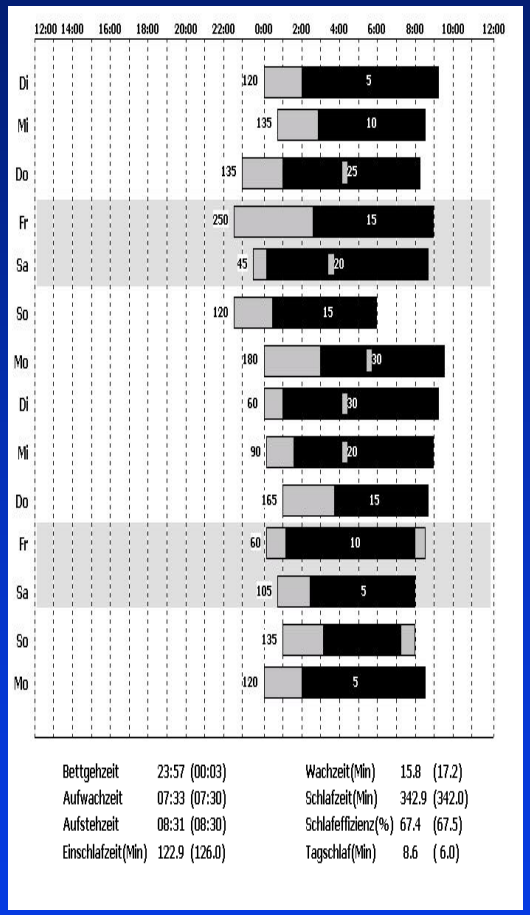
INITIAL - MIDDLE - LATE INSOMNIA

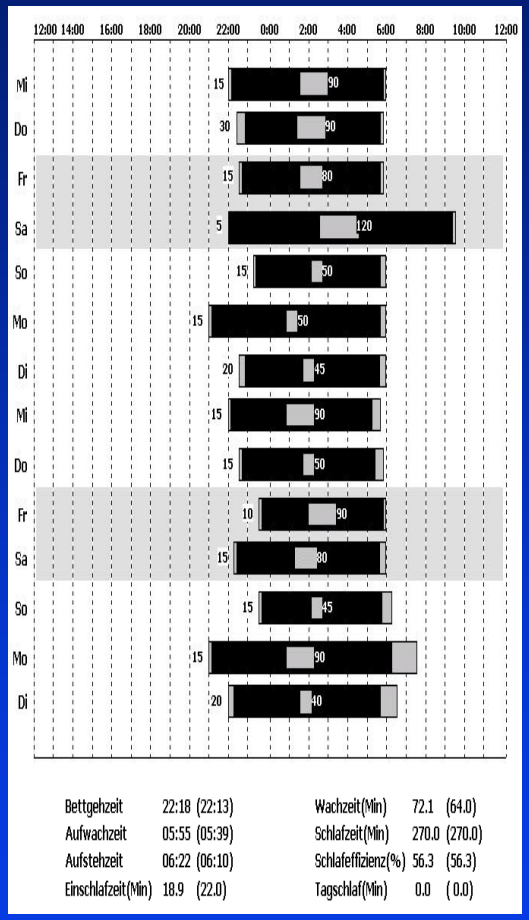


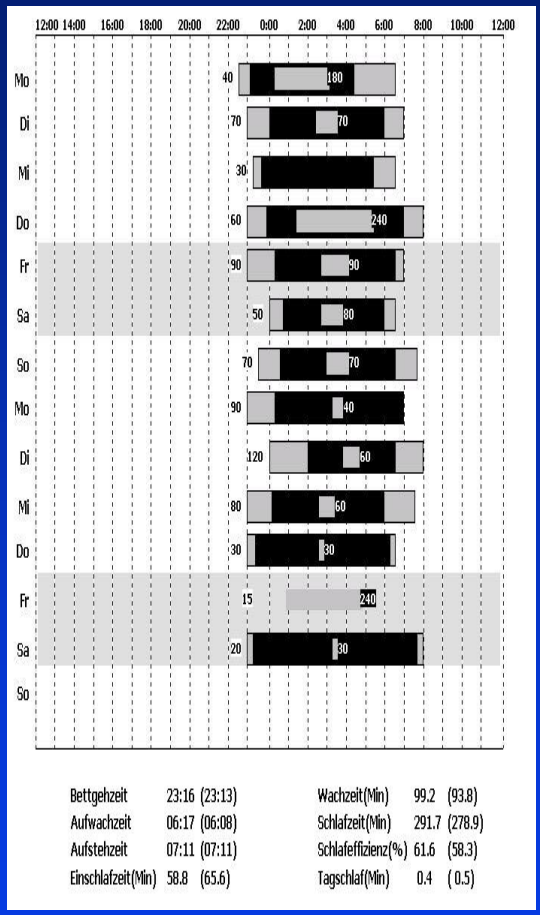
INITIAL - MIDDLE - LATE INSOMNIA



INITIAL - MIDDLE - LATE INSOMNIA

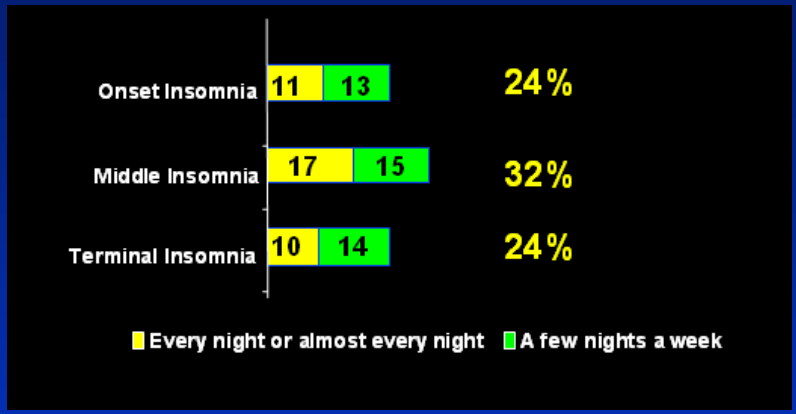






Compliments of Dieter Riemann

VALUE OF SUBTYPING ?

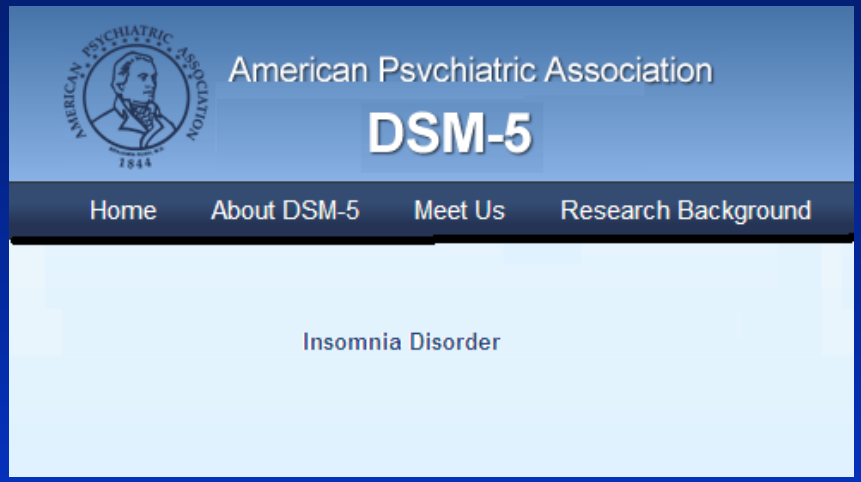


INITIAL IS ANXIETY

MIDDLE IS MEDICAL

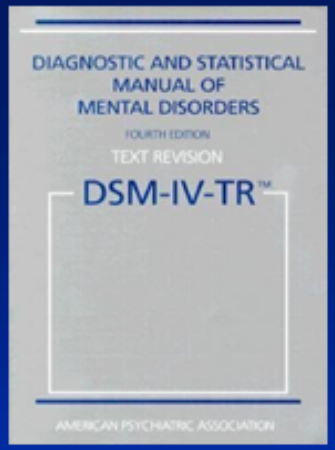
LATE IS DEPRESSION

DSM-5 AND ICSD-3
SOMETHING NEW



Insomnia Disorder

WHAT DO YOU SUSPECT THIS MEANS



PRIMARY INSOMNIA

A. The predominant complaint is difficulty initiating or maintaining sleep, or nonrestorative sleep, for at least 1 month.

B. The sleep disturbance (or associated daytime fatigue) causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The sleep disturbance does not occur exclusively [redacted] course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Par[redacted]

D. The disturbance does not occur exclusively during t[redacted] of another mental disorder (e.g., Major Depressive Disorder, Generalized Anxiety Disorder, a delirium).

E. The disturbance is not due to the direct physiologica[redacted] a substance (e.g., a drug of abuse, a medication) or a general medical condition.

THUS
THE CONCEPT OF SECONDARY INSOMNIA HAS BEEN ELIMINATED

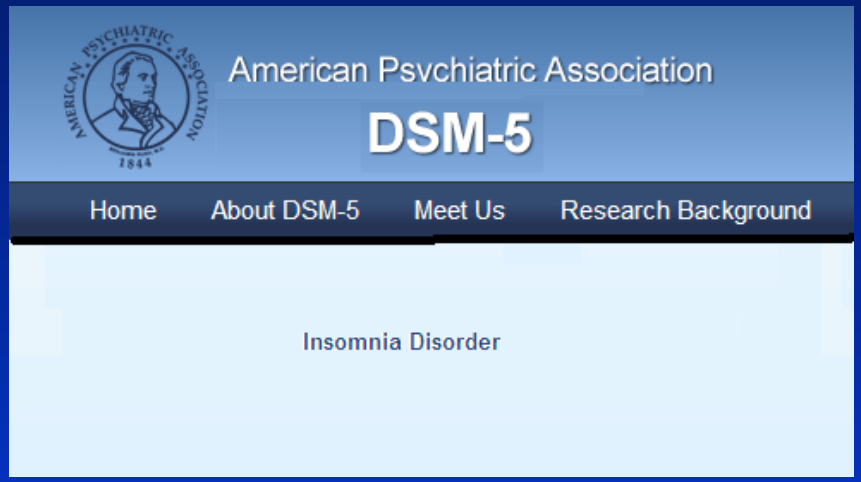
INSOMNIA WHEN CHRONIC IS NOT CLASSIFIED AS A SYMPTOM OF OTHER CO-OCCURING ILLNESSES BUT INSTEAD IT IS CLASSIFIED AS A DISORDER

THIS PARADAMATIC SHIFT WAS BROUGHT TO YOU BY

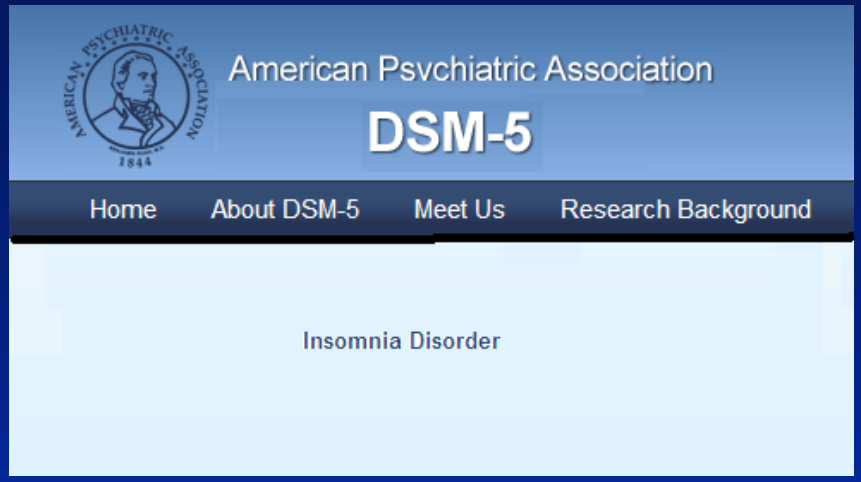
McCrae & Lichstein, 2001

Stepanski & Rybarczyk , 2005

Lichstein, 2006



Insomnia Disorder



A. The predominant complaint is dissatisfaction with sleep quantity or quality made by the patient (or by a caregiver or family in the case of children or elderly).

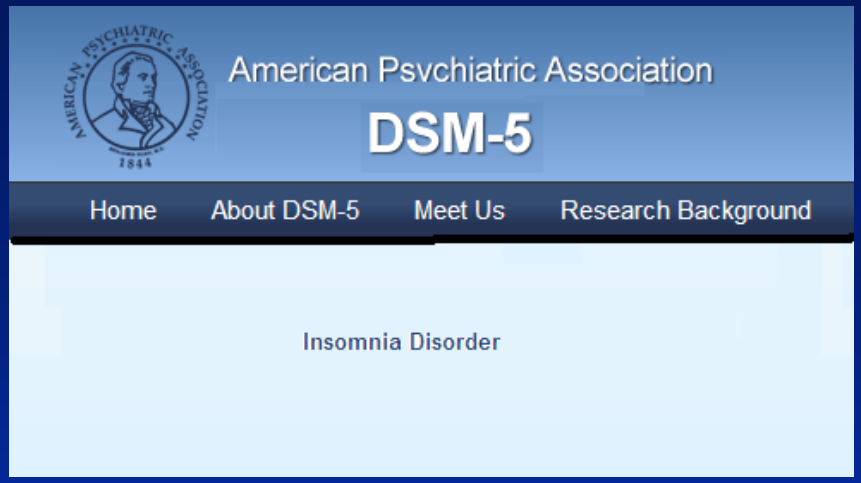
B. Report of one or more of the following symptoms:

C. The sleep complaint is accompanied by significant distress or impairment in daytime functioning as indicated by the report of at least one of the following:

D. The sleep difficulty occurs at least three nights per week.

E. The sleep difficulty is present for at least three months.

F. The sleep difficulty occurs despite adequate age-appropriate circumstances and opportunity for sleep.



B. Report of one or more of the following symptoms:

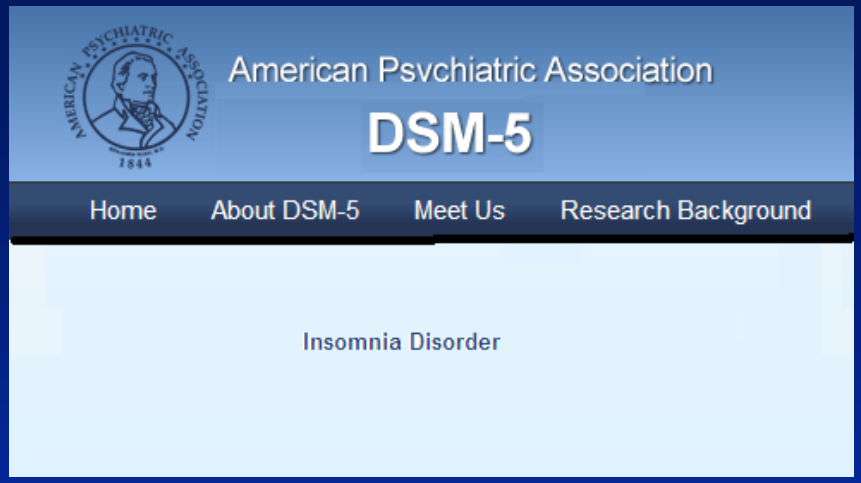
- Difficulty initiating sleep; in children this may be manifested as difficulty initiating sleep without caregiver intervention

- Difficulty maintaining sleep characterized by frequent awakenings or problems returning to sleep after awakenings (in children this may be manifested as difficulty returning to sleep without caregiver intervention)

- Early morning awakening with inability to return to sleep

- Non restorative sleep (wait)

- Prolonged resistance to going to bed and/or bedtime struggles (children)



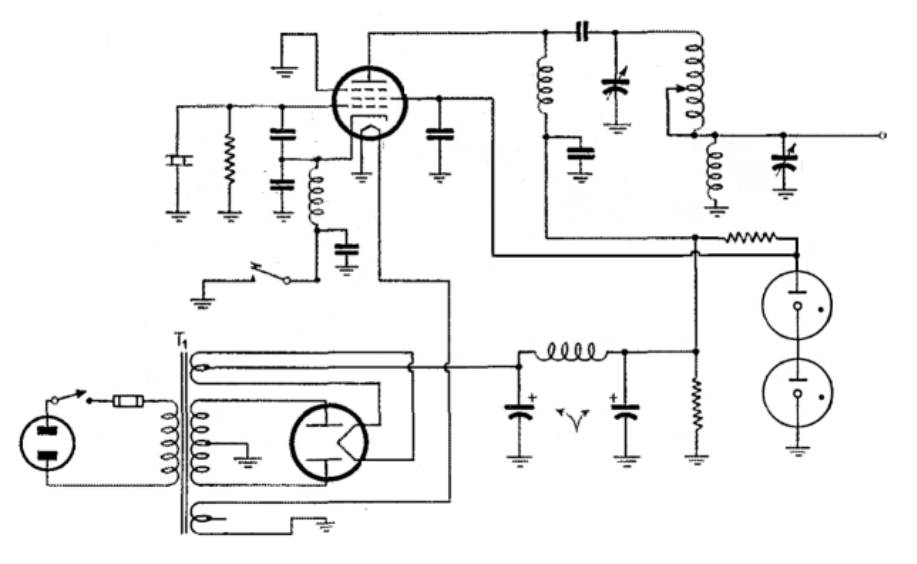
C. The sleep complaint is accompanied by significant distress or impairment in daytime functioning as indicated by the report of at least one of the following:

- -Fatigue or low energy
- -Daytime sleepiness
- -Cognitive impairments (e.g., attention, concentration, memory)
- -Mood disturbance (e.g., irritability, dysphoria)
- -Behavioral problems (e.g., hyperactivity, impulsivity, aggression)
- -Impaired occupational or academic function
- -Impaired interpersonal/social function
- -Negative impact on caregiver or family functioning (e.g., fatigue, sleepiness, etc.)

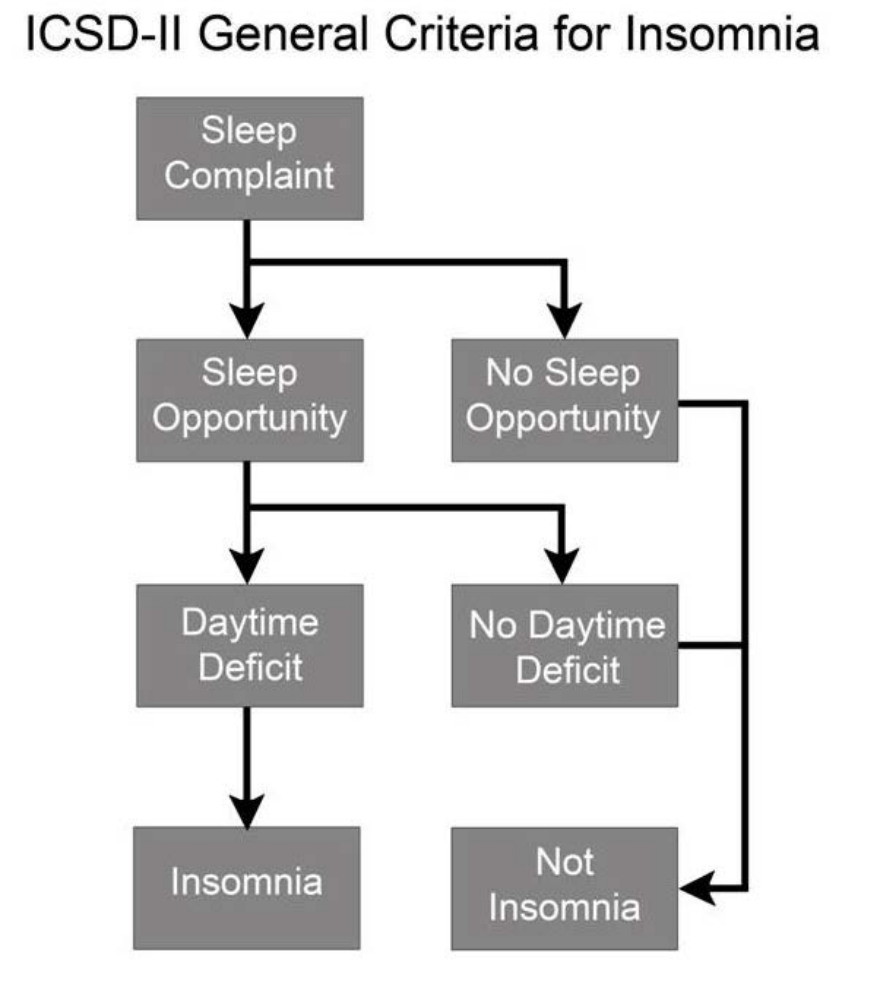
WHY THE EMPHASIS ON DAY TIME FUNCTION ?

RECAPITULATION

HOW ABOUT SOMETHING MORE SCHEMATIC ?



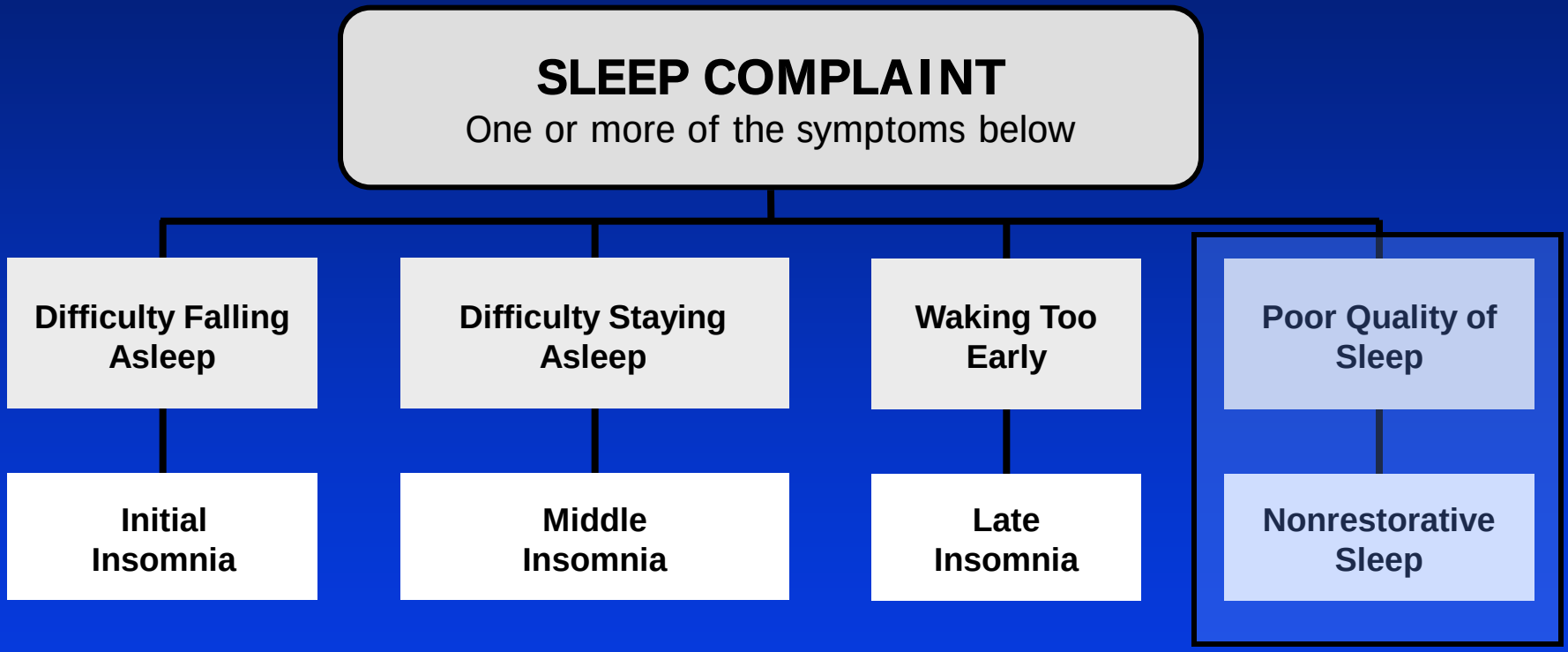
DEFINITION


ICSD-II General Criteria for Insomnia
Sleep Complaint
Sleep Opportunity
No Sleep Opportunity
Daytime Deficit
No Daytime Deficit
Insomnia
Not Insomnia

DEFINITION

WHAT IS MEANT BY A SLEEP COMPLAINT ?

DEFINITION


SLEEP COMPLAINT
One or more of the symptoms below
Difficulty Falling Asleep
Initial Insomnia
Difficulty Staying Asleep
Middle Insomnia
Waking Too Early
Late Insomnia
Poor Quality of Sleep
Nonrestorative Sleep

DEFINITION

WHAT IS MEANT BY SLEEP OPPORTUNITY ?

DEFINITION

SLEEP OPPORTUNITY

Nocturnal sleep difficulties occur despite the allocation of adequate time and circumstances (e.g., a quiet and dark bedroom) for sleep.

DEFINITION

SLEEP OPPORTUNITY

Quiet, dark and safe place

Speak to the issue of bedroom and safety

IF INSOMNIA IS SO > SA

WHY IS ADEQUATE SLEEP OPPORTNITY AN ESSENTIAL COMPONENT OF THE DEFNITION OF INSOMNIA

SO > SA = SN (-DC)

vs

SO > SA < SN (+DC)

DEFINITION

WHAT ABOUT

SEVERITY

DEFINITION

SEVERITY

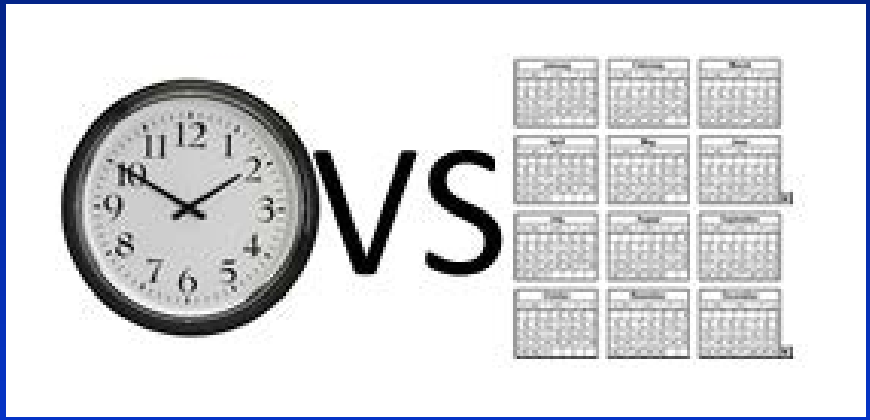
DEFINITION

SEVERITY

RULE OF 30

How long is long and corresponds to “complaint” ?
How long is long enough to correspond to consequence ?

A NOTE ABOUT ACUTE INSOMNIA



THE GENESIS AND TREATMENT OF INSOMNIA *

By HENRY DOUGLAS EATON, M. D., Los Angeles

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CLINICAL REVIEW

Acute insomnia: Current conceptualizations and future directions

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SUMMARY

Despite significant contributions made in the area of persistent/chronic insomnia, especially with regard to the underlying mechanisms driving its maintenance, the area of acute insomnia has received comparatively little attention. The aim of this paper is to review the literature with regard to understanding the situational and personaological circumstances that surround the development of acute insomnia. The review begins by examining how the existing diagnostic systems conceptualise acute insomnia. Theoretical models that explain, or inferentially explain, the transition between normal sleep and acute insomnia are then explored and evaluated. The review then examines the current evidence base in terms of the pathogenesis of acute insomnia from naturalistic and experimental studies. Overall, the findings from the review confirm the paucity of evidence available but perhaps more importantly highlight the need for a structured diagnosis of acute insomnia as the first step in a research and treatment strategy. To this end a diagnostic system, drawing on the existing literature on stress and the systems used to diagnose depression, is forwarded and justified and a research agenda advanced.

Introduction

In June 2005, the National Institute of Health (NIH)[1] published a 'State of the Science' statement on the manifestations and management of insomnia. Amongst its conclusions was the suggestion that the natural history of insomnia has not been adequately profiled and that targeted research in this domain is required. Very little is known about the pathogenesis and aetiology of insomnia and particularly the transition from normal sleep to acute insomnia, and from acute to chronic insomnia. This influential document brought the issue of the natural history of insomnia to the fore but perhaps not for the first time, as several prior calls for such research already existed in the literature.[2–4] Delineating the factors that moderate and mediate the transitions between normal sleep and acute insomnia and acute insomnia and chronic insomnia would allow for a better understanding of the development of the disorder whilst simultaneously providing a platform for preventative work.[5]

The aim of this review is to move the agenda on the natural history of insomnia forward, especially in the area of acute insomnia. The aim is accomplished by first reviewing how the various nosological systems define acute insomnia. This is followed by a comprehensive summary of how the existing models of insomnia conceptualise the acute form of the disorder and the potential transitions from normal sleep to acute insomnia. Following this review, the existing evidence for the conceptualisation and definition of acute insomnia is summarised in terms of predisposition and precipitation and critically evaluated. The review concludes with suggestions for future research starting with a set of proposed criteria for the diagnosis of acute insomnia and a speculative look at treatment options. Finally, it should be noted that the literature on acute insomnia is limited and thus much of the discussion must rely upon inferences that can be drawn from existing research on chronic insomnia.

The diagnosis of acute insomnia

When looking for 'caseness' (i.e., the occurrence or non occurrence of an illness, disease, or disorder), three central concepts are crucial in determining whether the individual has reached or exceeded a threshold and can then be classified as a 'case'.[6] These concepts all focus around the presenting symptoms and associated features and include the duration, frequency, and severity of symptoms. Additionally, when conceptualising the onset of illness, such as acute insomnia, one must also take into account the circumstances surrounding its initiation (i.e., triggering factors). There are three diagnostic systems used to define 'caseness' in sleep

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The proposed diagnostic for acute insomnia.

	Acute Insomnia
Trigger	1) Any life event or train of life events which results in a significant reduction in QoL from the individuals ideal 2) Distress at current situation
Minimum frequency	3 or more nights per week
Duration	3 days -3 months
Course	3- 14 days: acute 2- 4 weeks: transient 1- 3 months: subchronic
Qualitative severity	mild/moderate/severe as defined by the patient
Quantitative severity	(+30 min SOL; +30 min WASO)

QOL – quality of life.
SOL – sleep onset latency.
WASO – wakefulness after sleep onset.

SO THERE IS

ACUTE INSOMNIA
CHRONIC INSOMNIA

CHRONIC INSOMMIA TYPES INCLUDE

PSYCHOPHYSIOLOGIC INSOMNIA
PARADOXICAL INSOMINA
IDIOPATHIC INSOMNIA

CHRONIC/ACUTE SUBTYPES INCLUDE

INITIAL INSOMNIA
MIDDLE INSOMNIA
LATE INSOMNIA
MIXED INSOMNIA

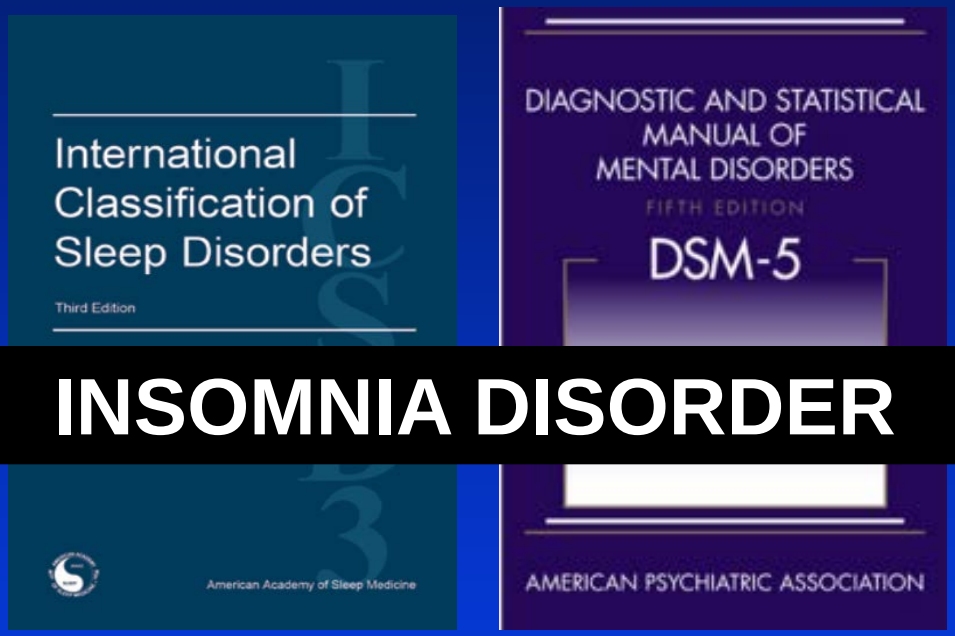
AND

PRIMARY INSOMNIA

VS

SECONDARY INSOMNIA

INSTEAD THERE IS



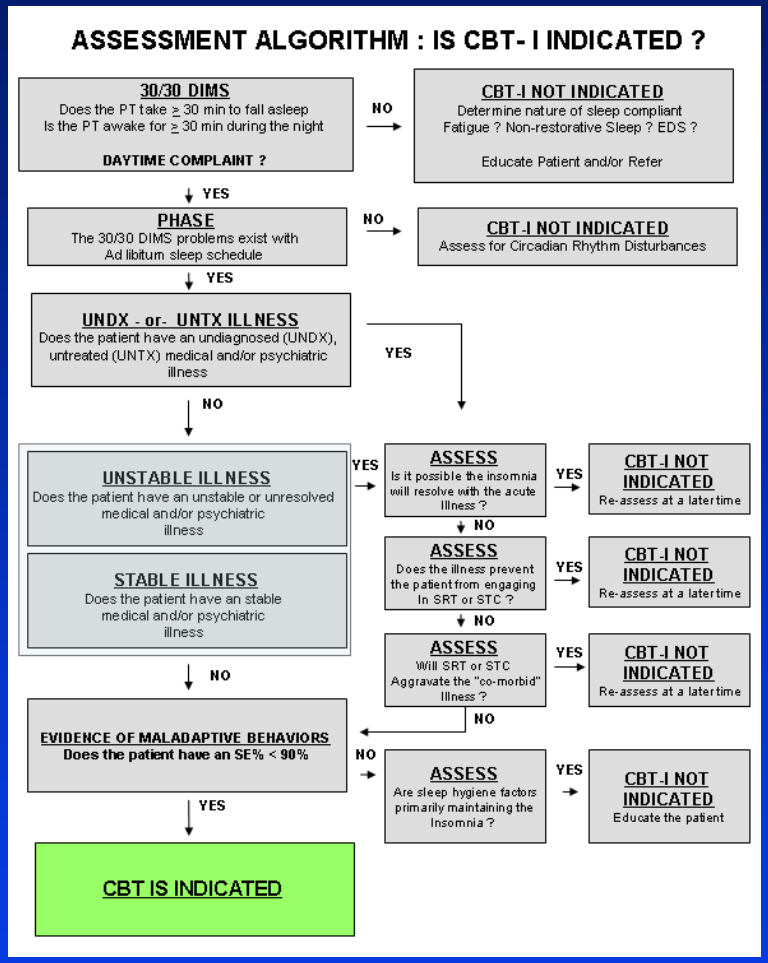
INSOMNIA DISORDER

FINALLY

IS Dx THE BEST WAY TO DETERMINE IF CBT-I IS INDICATED?

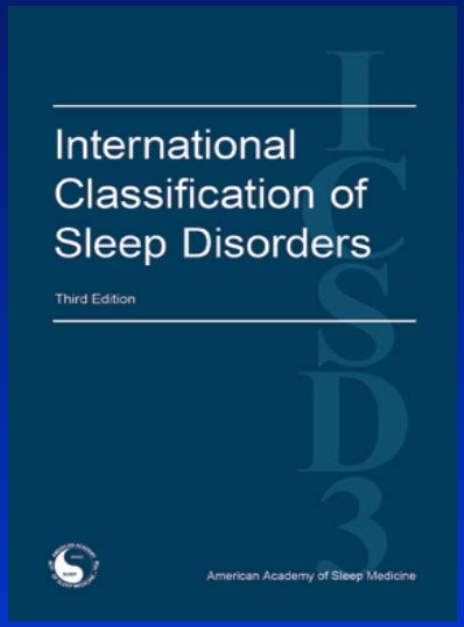
MAYBE NOT

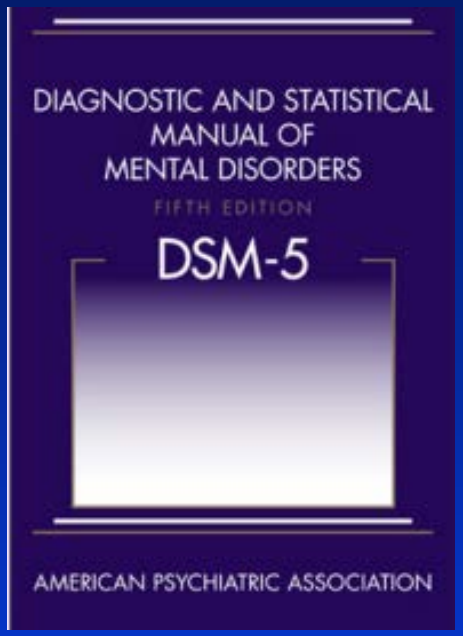
WHO IS A GOOD CANDIDATE FOR CBT- I ?



COVERED TOMORROW

THEN WHY BOTHER WITH Dx ?





KNOWING CAN HELP THE THERAPIST ANTICIPATE COMPLICATIONS

MORE ON THIS TOMORROW

BREAK