THE DEFINITION OF INSOMNIA
I KNOW IT WHEN I SEE 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]...”
DEFINITION - ETYMOLOGY
Word Origin & History

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

Online Etymology Dictionary, © 2001 Douglas Harper
Cite This Source

http://dictionary.reference.com/browse/insomnia
DEFINITION - COMMON DICTIONARY

AMERICAN DICTIONARY OF THE ENGLISH LANGUAGE
Dictionary

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

A persistent and prolonged inability to sleep.

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Cite This Source

http://dictionary.reference.com/browse/insomnia
DEFINITION - MEDICAL DICTIONARY

Taber's Cyclopedic Medical Dictionary
Medical Dictionary

Main Entry: **insomnia**

Pronunciation: in-ˈsäm-nə-

Function: **noun**

: prolonged and usually abnormal inability to obtain adequate sleep called also **agrypnia**

Merriam-Webster's Medical Dictionary, © 2002 Merriam-Webster, Inc.

Cite This Source

http://dictionary.reference.com/browse/insomnia
A Dictionary of Psychological Medicine

Agrypnia (ἄγρυπαι, wild or restless; ὠπός, sleep). A term for wakefulness or sleeplessness; one of the premonitory symptoms of various forms of insanity. (Fr. agrypnie; Ger. Schlaftlosigkeit).
AGRYPNIA PERTOESA (ἄγρυπνα; ὑπόρεος; pertoesus, disturbed). Sleeplessness from bodily disquiet, with attention alive to surrounding objects.
AGRYPNIA EXCITATA (ἀγρυπνία; ἐνυπός; excitō, I stir up). Sleeplessness due to mental excitement with listlessness as to surrounding objects.
ACROPHNIA SENILIS (ἀγρίος; ὑπνος; ἁνίλις, 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
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
A FORM OF INSOMNIA THAT IS CONCEPTUALIZED AS BEING PERPETUATED, IN LARGE MEASURE, BY ORGANIC FACTORS
INSOMNIA NOS
ARE THERE SUBTYPES OF INSOMNIA?

PRIMARY INSOMNIA

IDIOPATHIC  PARADOXICAL  PSYCHOPHYS  INADEQUATE SH  PHYSIOLOGIC

INITIAL  MIDDLE  LATE
INITIAL - MIDDLE - LATE INSOMNIA
INITIAL - MIDDLE - LATE INSOMNIA

Normal Adult

Patient with Primary Insomnia

Awake REM
1 2 3 4
1 2 3 4

Time (h)

INITIAL INSOMNIA
MIDDLE INSOMNIA
LATE INSOMNIA

SLEEP MAINTENANCE 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
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 during the course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder, or a Parkinson Disease.

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 physiologic effects of 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
    - Daytime Deficit
      - Insomnia
    - No Daytime Deficit
      - Not Insomnia
  - No Sleep Opportunity
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
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 OPPORTUNITY AN ESSENTIAL COMPONENT OF THE DEFINITION OF INSOMNIA

SO > SA = SN (-DC)

vs

SO > SA < SN (+DC)
DEFINITION

WHAT ABOUT SEVERITY
DEFINITION

CRITERIA

SEVERITY
DEFINITION

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
CLINICAL REVIEW

Acute insomnia: Current conceptualizations and future directions

Jason G. Ellis, Philip Gehman, Colin A. Espe, Dieter Riemann, Michael L. Perlis

A selection of the text:

Introduction

In June 2005, the National Institute of Health (NIH) 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 epidemiology 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 that perhaps not for the first time as several prior calls for such research already existed in the literature.4 5 6 Determining the factors that moderate and mediate the transitions between normal sleep 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.7

The aim of this review is to provide a comprehensive and critical 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 transition 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 ‘insomnia’ (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.’ 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 insomnia, 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 ‘insomnia’ in sleep
The proposed diagnostic for acute insomnia.

<table>
<thead>
<tr>
<th>Acute Insomnia</th>
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| **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 INSOMNIA TYPES INCLUDE
PSYCHOPHYSIOLOGIC INSOMNIA
PARADOXICAL INSOMNIA
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
IS Dx THE BEST WAY TO DETERMINE IF CBT-I IS INDICATED?

MAYBE NOT
WHO IS A GOOD CANDIDATE FOR CBT-I?

ASSESSMENT ALGORITHM: IS CBT-I INDICATED?

- 30/30 Dims: Does the PT take >30 min to fall asleep? Is the PT awake for >30 min during the night.
  - Yes → DAYTIME COMPLAINT?
  - No → CBT-I NOT INDICATED

- Daytime Complaint?
  - Yes → PHASE
    - The 30/30 Dims problem exist with diurnal sleep schedule.
  - No → CBT-I NOT INDICATED
  - Assess for Circadian Rhythm Disturbances

- Phase
  - Yes → UNDX or UNITX ILLNESS
    - Does the patient have an undiagnosed (UNDX), untreated (UNITX) medical and/or psychiatric illness.
  - No → CBT-I NOT INDICATED

- UNDX or UNITX ILLNESS
  - Yes → UNSTABLE ILLNESS
    - Does the patient have an undiagnosed or unresolved medical and/or psychiatric illness.
  - No → CBT-I NOT INDICATED

- UNSTABLE ILLNESS
  - Yes → STABLE ILLNESS
    - Does the patient have a stable medical and/or psychiatric illness.
  - No → CBT-I NOT INDICATED

- STABLE ILLNESS
  - Yes → EVIDENCE OF MALADAPTIVE BEHAVIORS
    - Does the patient have an SE% < 95%.
  - No → CBT-I NOT INDICATED

- EVIDENCE OF MALADAPTIVE BEHAVIORS
  - Yes → CBT-I INDICATED
  - No → CBT-I NOT INDICATED

COVERED TOMORROW
THEN WHY BOTHER WITH Dx?

KNOWING CAN HELP THE THERAPIST ANTICIPATE COMPLICATIONS

MORE ON THIS TOMORROW
BREAK