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CASE STUDY

A CASE STUDY IN INSOMNIA

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INTRODUCTION

"MRS.X a 42-year-old woman is referred to the hospital with a complaint of chronic, severe insomnia affecting her daytime functioning. The single mother of three teenage boys, she first experienced insomnia eight years ago when bankruptcy threatened her small business. Although the business recovered a year later, 'her insomnia has remained almost unchanged over the next eight years.

Medication History: She has taken Temazepam, Zolpidem, and Zaleplon, as well as several antidepressants including Trazodone, Amitriptyline, and Mirtazapine. All have been unsuccessful. Although an initial benefit was derived from some of these medications, She gave up on each of them after a few weeks because of their side effects and/or lack of efficacy.

Social History: She feels she is just "hanging on by her fingernails," and that looking after her business and her sons takes all of her energy. Her insomnia has forced her to give up her social life, including her fly-fishing hobby and gym workouts. She feels depleted and stressed all of the time. She has begun to drink four to five strong cups of coffee per day to keep awake and tries to catch a nap whenever possible.

Review of Sleep Pattern: She tries to go to bed around 11:00 PM. She usually falls asleep in less than 15 minutes, but occasionally it seems to take her hours to fall asleep. She wakes up three to four times per night, and at least one of these awakenings lasts two to three hours. She gets frustrated when she "sees the clock ticking away;" in response, she usually gets out of bed to work on the computer until she becomes sleepy, which often does not happen until around 5:30 AM-which is the time she should be getting up. At that time, She falls into a very deep sleep and may not awaken until 7:00 or 8:00 AM.

Physical Examination: Her general physical evaluation found her to be healthy but suffering from excessive sleepiness, fatigue, and a lack of energy. A concomitant psychiatric interview revealed high stress levels, but no evidence of depression, anxiety, or other psychopathology. She was referred to a sleep center, where her screens for restless legs syndrome and possible respiratory disturbances were negative. An evaluation of her current lifestyle -designed to identify behaviors and thought patterns that might contribute to her insomnia - uncovered situational distress and a weak coping style.

***Treatment*:** She was also recommended the following sleep hygiene improvements: decrease caffeine intake; avoid sleeping late in the morning at all costs; conceal the alarm clock to avoid checking the time during the night; and, when she is unable to sleep, to do some light reading rather than working. These measures did not provide adequate relief, however. She enrolled in a relaxation course (using meditation). She also completed two sessions of cognitive therapy in order to address her dysfunctional beliefs about sleep, which included "I have to give up everything enjoyable to get better sleep."

She was also referred to an organization to help review her business practices. It was suggested that her business had grown enough to employ a full-time secretary. After she successfully hired this new staff person, she was advised to

use the time gained to address her personal needs for exercise, social activities, and hobbies.

After six months, her sleep improved, and she reported that she now slept poorly only about two nights per week. An as-needed hypnotic was prescribed for her to use if her sleep was poor for two or more nights in a row, or if she anticipated being particularly stressed the following day.

Nursing diagnosis

1. Disturbed sleep pattern related to changes in routine due to hospitalization and pain

Or

Disturbed sleep pattern related to lack of cues for day- night schedule; manifested by erratic sleep schedule, frequent naps and nocturnal wandering

D. Nursing intervention	Rationale
*offer meals at regular times, corresponding to client's previous pattern	*mealtimes are important social cues, that reinforce circadian rhythms, which tend to weaken with advancing age
*provide active meaningful activities during daytime hours, including exposure to natural light, and an outdoor environment when possible	*light exposure is communicated through the retina to the suprachiasmatic nucleus, helping to set the circadian clock
*monitor frequency and duration of naps	*napping is not contraindicated but is best at the time of day opposite to the midpoint of the nocturnal sleep period. Short naps are preferable to avoid deep sleep
*create an individualized bedtime ritual that includes a quieting activity, a light carbohydrate snack, going to the bathroom and settling a routine	*reduced stimulation and rituals associated with sleep enhance sleep onset
* Do not waken even if incontinent. Change and assist the client to the bathroom when he or she spontaneously awakens	*older adults who can turn themselves generally do better to have their sleep undisturbed and tend to waken spontaneously if wet when their sleep cycle lightens
*if turning or other care is necessary, try to provide for periods up to 2 hours of undisturbed sleep time whenever possible	* Sleep cycles average 90 mts. A sleep latency of 20- 30 mts mean it would take about 2 hours to experience a full sleep cycle.

Follow-up: One year later, she reported that her life was much improved. Her business was running much more smoothly and she felt that had more time to spend with her sons. She continued to practice good sleep habits and daily meditation and took the hypnotic when necessary, about twice per month. She was quite satisfied with these results. A second follow-up conducted five years after initial treatment showed she was sleeping normally without the use of hypnotics.

Nursing Process

A. Assessment: Assess client's usual sleep habits and recent sleep quality as part of the initial nursing history. If sleep quality is reported to be poor, explore the nature of Disturbances by noting the following:

- Usual activities in the hour before retrieving
- Sleep latency
- Number and perceived cause of awakenings
- Regularity of sleep pattern
- Consistency of rising time
- Frequency and duration of naps
- Events associated with initial onset of sleep disturbances
- Ease of falling asleep in places other than the usual bedroom
- Situations in which client fights sleepiness
- Daily caffeine intake
- Use of alcohol, sleeping pills, and other medications
- Incidence of morning headaches
- Frequency of snoring, apparent pauses in breathing, and kicking movements
- Objective data may include visible signs of fatigue and lack of sleep, such as circles under the eyes, lack of coordination, drowsiness and irritability.

CONCLUSION

It is important to encourage patients to acquire physiologically accurate knowledge about sleep and to encourage practitioners to have an open mind when diagnosing and treating these patients. Also, to avoid unnecessary worsening of insomnia, practitioners need to maintain calm clinical support as the patient proceeds through various phases of assessment and treatment.

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