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BOARD REVIEW CORNER

The Ambivalent Sleeper

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A 27-year-old, fit male Veteran who had received a prescription for Ambien was seen in sleep clinic, saying "I just can't sleep." He reported wanting more sleep and also feeling uncomfortable "needing a medication to sleep." The Veteran initially experienced sleep difficulties in Iraq, when he was prescribed Ambien to facilitate sleep during irregular work schedules. He received another prescription for Ambien when returning stateside one year before his clinic visit. Since that time, he attempted to discontinue use of the medication several times, but he has been unsuccessful. Within the last year, he has been diagnosed with gastroesophageal reflux disease (GERD), which is controlled by medications. He has no other medical diagnoses.

Upon further questioning about his current sleep habits, the Veteran stated that he takes Ambien every night immediately before retiring to bed. However, he does not retire to bed until 02:00, often spending this time alone in the evening playing video games. Prior to bedtime, he checks the locks on the doors and windows and makes sure his loaded gun is within reach should he encounter an intruder. Once in bed, he falls asleep quickly but sometimes awakens in the middle of the night with nightmares about his combat experiences in Iraq. He awakens with or right before his alarm clock at 06:00, often feeling unrested. The Veteran is employed part-time as a welder in the mornings and is seeking a job with the police department. Every day, he drinks one energy drink in the morning and one after lunch to help with fatigue. Once a month, he "parties" with his friends, drinking up to a 12-pack of beer and smoking up to 6 cigarettes. He does not snore, except on days that he drinks alcohol. The Veteran reports occasionally awakening with the sheets tangled or off his bed, especially when experiencing nightmares, but he denies experiencing any unusual sensations in his limbs. Most days, the patient reports feeling "strung out" but denies experiencing daytime sleepiness (Epworth Sleepiness Scale score = 2). He is concerned that his lack of sleep may be affecting his ability to concentrate and take the police department placement exams.

You are concerned that this Veteran may have some mental health problems, including posttraumatic stress disorder (PTSD), and offer a referral to the mental health clinic. The Veteran declines insistent that PTSD is "for wimps" and that a mental health diagnosis would eliminate him from his career ambitions as a police officer. You agree to taper his Ambien while examining other strategies to improve his sleep.

WHAT IS THE BEST NEXT STEP?

a. **Prescribe prazosin 1 mg to help with nightmares.**
b. **Counsel to the appropriate use of caffeinated and alcoholic beverages. Provide patient with a sleep hygiene handout.**
c. **Counsel on the importance of mental health treatment and insist upon a referral.**
d. **Explore obstacles to an earlier bedtime and encourage the Veteran to eliminate use of all combat-oriented video games, especially in the evening.**
e. **Split-night PSG with CPAP titration (if necessary).**
f. **Nothing else. The patient's major reason for the visit was to discontinue Ambien.**

CORRECT ANSWER:
d. Encourage Veteran to eliminate use of combat-oriented video games and explore obstacles to an earlier bedtime.

This patient has a history and sleep pattern consistent with insomnia, insufficient sleep type. Although he has a delayed bedtime, he falls asleep quickly and often arises before his alarm clock, suggesting that arousal symptoms associated with PTSD are responsible for the delay rather than a circadian rhythm timing problem. Exposure to combat, nocturnal hypervigilance, and safety checking behaviors are also consistent with either clinical or subthreshold PTSD. To support this interpretation, the patient has developed GERD, a condition often associated with stress. Patients with PTSD commonly report avoiding sleep or darkness for fear of nightmares, silence, memories related to traumatic experiences, or vulnerability associated with being in a state of nonvigilance. To avoid sleep, the Veteran may also play combat-related or other video games that provide stimulation and unhelpful exposure to combat cues that contribute to a worsening of PTSD symptoms, including replaying combat themes in nightmares. Unfortunately, there is evidence that even low to moderate evening room light can alter the timing of circadian rhythms,[1] which may partially explain the continued delay in bedtime.

Treatment for inadequate sleep relies upon exploring cognitive and behavioral obstacles that contribute to the maintenance of a small sleep window. Once identified, it might be useful to discuss ways that increased time in bed and more sleep might improve mental health and cognitive functioning. In other words, this patient could benefit from a combined approach using elements of cognitive behavioral therapy for insomnia with an Ambien taper that would encourage him to increase his sleep window by taking the Ambien earlier in the night.[2]

In this example, nightmares would not be targeted immediately by prazosin because the patient has already expressed a dislike of medications, which is why option A would be inaccurate. Prazosin is certainly a viable treatment option; however, other effective, non-medication treatment options exist for nightmares that might be more in line with patient preference (i.e., imagery rehearsal therapy). Moreover, it is debatable whether nightmares represent the chief complaint. The patient indicated that he is satisfied with his sleep on Ambien, an insomnia treatment, albeit uncomfortable using a sleep medication, which suggests that he would prefer a similar insomnia treatment that was non-medication based.

For similar reasons, option (c), insistence upon a referral to mental health, would be unhelpful to this patient. He has indicated that he would not attend a mental health appointment due to realistic concerns of negative effects on his employment. Attention to patient preferences for treatment will facilitate treatment adherence and may increase long-term positive outcomes. At some point in the future, medications or mental health referrals (two options found undesirable by the patient at this time) may be in order.

Based on this rationale, one might say that option (f) would be most appropriate because it is in line with the patient's preference to discontinue Ambien. However, the patient has already tried discontinuing his medications without success, likely due to unhelpful behavioral patterns he has established at night. In changing habitual behaviors (like sleep), it is often ineffective to discontinue one reliable source of support without first teaching skills or implementing a successful alternative behavior first; this is why option (f), is not the best choice. The point of these three options is to illustrate the importance of a collaborative approach to insomnia treatments that balances patient preferences and provider knowledge.

Use of caffeine and alcohol likely contribute to the patient's insomnia. While this is an appropriate target for treatment, it is not the best option at this time. Sleep hygiene is not an effective stand-alone treatment for insomnia.[3] Evidence-based approaches to insomnia should be tried first. Moreover, counseling on the reduction of caffeine and alcohol (option b) does not explore or address potential underlying reasons for the use of these substances. For instance, caffeine and nicotine may facilitate a heightened state of alertness, and alcohol may temporarily self-medicate hyperarousal symptoms. Without an understanding of the functional benefits of these substance-using behaviors, counseling is likely to be ineffective. For this reason, option d, which includes an exploration of obstacles associated with an earlier bedtime, is a better choice.

Our young, fit patient does not regularly snore or have excessive daytime sleepiness, so polysomnography to assess sleep apnea is unlikely to assist substantially in the diagnosis (option e is incorrect). A split-night PSG may be warranted in the future, should sleep not improve with cognitive and behavioral techniques and especially given the GERD diagnosis, which is often associated with OSA.

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DISCLOSURE STATEMENT

The authors have indicated no financial conflicts of interest.