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Journal of Sleep Disorders & Therapy

Commentary

Diagnostic Criteria for Insomnia

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The clinical diagnosis of insomnia is based on complaints about falling asleep, staying asleep, getting up early in the morning and resulting daytime dysfunction. This daytime dysfunction can manifest in a variety of ways, including fatigue, malaise, Poor attention, concentration or memory; impaired social, family, work or academic performance. Mood disorders, irritability, drowsiness, hyperactivity, impulsivity, aggression, decreased motivation, error susceptibility, sleep concerns or dissatisfaction with sleep. The sleep disturbance must occur despite adequate opportunity for sleep in a safe, dark environment. Duration is also key to the diagnosis: To meet criteria for chronic insomnia according to the third edition of the International Classification of Sleep Disorders (ICSD-3) or for persistent insomnia according to the DSM-5, symptoms must be present at least three days per week for at least three months. Short term insomnia or episodic insomnia has the same criteria as chronic insomnia, but lasts for fewer than three months. If the sleep disorder is completely explained by another physical, mental, or sleep disorder, the patient does not meet the diagnostic criteria for insomnia. However, insomnia is not the only symptom of other mental illnesses, as was once thought. If insomnia is severe enough to require independent clinical management, even if it is triggered or intermittent by another disorder, it should be recognized as a separate comorbidity.

Previously, both ICSD and DSM described different subtypes of insomnia. These include psychophysiological insomnia, paradoxical insomnia, idiopathic insomnia, childhood behavioral insomnia, psychiatric insomnia, medical insomnia, and drug or substance insomnia.

Objectively short sleep subtypes of insomnia have been described and are characterized by their potential for association with increased morbidity. These individuals meet the criteria for chronic insomnia and, when measured objectively, sleep less than 6 hours per night on average. This combination of insomnia and short sleep time is associated with hypertension, type 2 diabetes, and decreased neurocognition. Therefore, this could eventually fall into another category in future versions of the insomnia classification.

A complete list of medications, including over-the-counter medications and substances of abuse, should be collected, as many medications can interfere with sleep.

Antidepressants such as Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin Norepinephrine Reuptake Inhibitors (SNRIs), and Monoamine Oxidase Inhibitors (MAOIs) can cause individualized sedation or irritation. Therefore, patients may consider shifting their daily dose from morning to evening and vice versa to see how this affects sleep.

Over the counter allergic drugs often contain stimulants such as pseudoephedrine and phenylephrine, which patients may not be aware of as contributing to insomnia. Withdrawal symptoms can also be contributed, for example, from alcohol, benzodiazepines, or opioids. Pulmonary medications such as salbutamol and theophylline can also cause insomnia.

Women are more likely to report symptoms and episodes of insomnia than men and are more likely to be diagnosed with insomnia. The ratio of males to females is 1: 1.4 for insomnia symptoms and 1: 2 for insomnia diagnosis. The prevalence of insomnia increases with age in both men and women.

Insomnia is associated with low income, low education, divorce or widows. It is also strongly associated with disability, with half of people with insomnia reporting multiple physical problems. People with insomnia tend to have difficulty assessing their health.

Insomnia is strongly associated with psychiatric disorders, most commonly depression, anxiety, and post-traumatic stress disorders. Cross-cultural, most people with major depression report insomnia, and people with insomnia are more likely to be depressed. Insomnia is also a predictor of the development of mental health problems such as depression, anxiety, bipolar disorder and suicide.

Insomnia has been reported as a side effect of antihypertensive drugs, and beta-blockers are known to lower melatonin levels, but there is widespread evidence of the direct effects of these drugs on sleep.

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Received: 03-Oct-2022, Manuscript No. JSDT-22-18573; **Editor assigned:** 05-Oct-2022, PreQC No. JSDT-22-18573 (PQ); **Reviewed:** 18-Oct-2022, QC No.JSDT-22-18573; **Revised:**26-Oct-2022,Manuscript No. JSDT-22-18573 (R); **Published:**31-Oct-2022,DOI: 10.35248/2167-0277.23.12.443

Citation: Rian B (2022) Diagnostic Criteria for Insomnia. J Sleep Disord Ther. 12:443.