

Treating Insomnia in Older Adult Patients

A Q&A With Sanford Auerbach, MD



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EDITORS FROM THE AMERICAN JOURNAL OF MANAGED CARE® (AJMC®) spoke with Sanford Auerbach, MD, to discuss considerations for treating older adults with insomnia. He is the director, Sleep Disorders Center; director, Sleep Medicine Fellowship Training Program; and associate professor of neurology, psychiatry, and behavioral neurosciences at the Boston University School of Medicine in Boston, Massachusetts.

AJMC®: How does sleep change as people age?

AUERBACH: As people age, the human body undergoes changes, and the body's sleep clock advances. It becomes geared toward going to bed earlier and waking up earlier. Sleep becomes more fragile and sensitivity to aspects that impact sleep increases. All the aspects that would cause insomnia in a younger patient are amplified in older patients.¹ [For example,] if an older adult wakes up in the middle of the night, it is harder to get back to sleep. Once that sleep disruption occurs, particularly if it is enough to cause some cognitive impairment, the patient is more vulnerable to the adverse effects of lost sleep.

In addition, older adults have more medical conditions that disrupt sleep, such as chronic pain, and they may have been prescribed medications that can disrupt sleep.^{2,3} Also, a number of neurological conditions are associated with sleep problems, such as many of the neurodegenerative disorders, like Alzheimer disease (AD) and Parkinson disease. [Patients with those disorders] have a greater risk of developing disrupted sleep, and in those cases the consequences of disrupted sleep are more complicated than in patients without neurodegenerative disease.³⁻⁶ For example, if an elderly person with dementia of any kind is not sleeping well through the night, it becomes a major problem. They wake up in the middle of the night and they are confused and agitated, which in turn also makes it difficult for their caregiver to sleep through the night. If their caregivers don't sleep well during the night, it jeopardizes the whole caregiving system.

Furthermore, if elderly patients are getting up in the middle of the night and wandering, it puts them at risk of other things, such as falls.⁷ The prevalence of disordered sleep increases with age,¹ and this can lead to insomnia, the 2 major components of which are: 1) the patient must present with some difficulty either initiating sleep, or staying asleep, waking up too early, or having more fragmented sleep; and 2) this disrupted sleep pattern must have a negative impact on the patient's daytime functioning. The patient has to have both components (for a true diagnosis of insomnia).⁸

AJMC®: What is the prevalence of insomnia in older adults?

AUERBACH: It is quite high. In the population of adults 65 years or more, more than a third have reported sleep problems,⁹ and half of those probably have very significant sleep problems that impact their lifestyle.

Of the older patients I see in my practice who present with memory complaints, a large percentage have sleep problems. This is because whatever is causing their memory complaint is also causing their sleep problem or

because their sleep problems are contributing directly to the memory complaint. Sleep disruptions in the elderly will commonly lead to cognitive complaints. For example, a patient with early AD will commonly have a sleep disruption.

AJMC®: How do you treat insomnia in older adult patients?

AUERBACH: Clinicians should start with ensuring the patient has good sleep hygiene, which is made up of a number of good habits that will allow the patient to develop a regular routine of sleep.¹⁰ One of these habits is to develop a regular routine, which includes determining the best bedtime for the patient. Because older adults

tend to have a natural shift in their bedtime to go to sleep earlier, their bedtime should be adjusted to that new natural sleep clock. Caffeine and alcohol should be avoided close to bedtime to help the patient transition to sleep because caffeine can be stimulating and, although alcohol may have an initial sedating effect, it also can have a rebound effect. Patients also should maintain some sort of regular exercise during the day, and the sleep environment should be appropriate for sleep. This may include

removing the stressors of the day from the area (ie, TVs, computers) and ensuring that the environment is generally free of light, in particular blue light, which has been to promote wakefulness. It should be quiet, and most people sleep better if their sleep environment is slightly cool as well. Then, the patient needs to be sufficiently relaxed to be able to transition into sleep. [Relaxation techniques] will vary from person to person and should be [individually] tailored. For example, reading in bed is very helpful in encouraging relaxation and sleep in some patients, whereas in others, they will [tend to] continue reading the book until they finish it, staying up all night [in the process]. The same goes for watching television. What is stimulating for one person might be sedating for someone else. Some people cannot sleep in a completely dark room, and so steps can be taken to at least minimize the amount of blue light.¹⁰

If steps have been taken to ensure good sleep hygiene and the patient is still having trouble sleeping, the next step is to ensure that the management of their other medical conditions and medications that may be

interfering with sleep has been optimized. Once that is complete, the next step would be to consider cognitive behavioral therapy for insomnia (CBTI).¹¹ CBTI incorporates sleep hygiene into a group of techniques that are geared toward getting people to sleep better. These techniques include things like sleep restriction therapy and ensuring that the patient is not spending too much time in bed. This involves determining how much time a patient actually needs to be in bed, and then only allowing the patient to be in bed for that amount of time. If it's slightly less, that's been shown to increase the efficiency of their sleep. For example, if a patient needs 7 hours of sleep, through therapy, they may only be allowed in bed for 6.5 hours. That time includes naps. This isn't to say

naps are bad. If a patient takes a nap during the day, it just means that they need less sleep at night. For some people, eliminating naps helps improve their sleep efficiency at night. If a patient doesn't eliminate the nap, it must be accounted against the amount of time they sleep at night and should be included in the amount of time spent in bed. In the very beginning, that can improve the efficiency of sleep while the patient is in bed. Then, over time, the amount of time the patient would spend in bed could increase.¹¹

“ Once that sleep disruption occurs [in an older adult], particularly if it is enough to cause some cognitive impairment, the patient is more vulnerable to the adverse effects of lost sleep. ”

If the patient could be experiencing disorder sleep as a result of anxiety, then the anxiety needs to be addressed. I see 2 comorbid conditions most commonly [in my practice]: anxiety and cognitive impairment. First and foremost is anxiety. In that situation, rather than giving a patient medications that work on sleep, I focus on treating the anxiety. When a patient has a cognitive impairment, such as AD, dementia, or a vascular disorder that contributes to cognitive impairments, and I have tried all the techniques we previously discussed, then I will prescribe a medication to help with sleep. When clinicians prescribe medications for sleep disruptions in this population—particularly if a patient has cognitive impairment, such as AD, and has a caregiver—they want to ensure that they prescribe a medication [to ensure that] the patient will sleep through the night and will not get up and wander. Even if the patient has 24-hour care, if they are up wandering at night, that will impact the sleep of their caregiver, and the caregiver will then be compromised during the day.

The urgency to ensure [that the patient has adequate treatment] in those situations has increased [over time],

particularly as the patient's caregiver may be an elderly spouse who is [also] unable to cope with the sleep deprivation.

AJMC®: How do you decide what medications to use to treat insomnia in older adults?

AUERBACH: The choice of appropriate medication to help with insomnia in a particular patient is based on several aspects. First is the comfort level of the patient. Some patients will state that they do not want to be on medication. Second, pricing constraints have to be considered for some patients. Sometimes, patients have to fail several therapies [covered by their insurance] before their insurance company will cover a [particular] medication, or the medication may not be covered at all and the patient cannot afford it. And, third, each medication comes with adverse effects that need to be considered, particularly in light of a patient's comorbid conditions.^{2,3} [These medications] are also listed in the American Geriatrics Society Beers Criteria.¹² [When faced with the situation] of prescribing a medication to an older adult that is listed on the Beers Criteria as being associated with potential adverse effects, [the clinician] needs to weigh the pros and cons of using that medication. For example, some medications, such as benzodiazepines, may have anticholinergic effects that may cause cognitive impairment. Stimulant medications and medications to treat anxiety, which are common in elderly patients, can make patients tired during the day, and some can cause insomnia. In addition, [the benefits of] medications such as diuretics need to be considered [because an adverse effect may be that] they cause a patient to get up in the middle of the night to urinate.¹²

The patients I see with sleep complaints usually present in 1 of 2 ways. In the first, the patient comes in with a sleep complaint, in which case I start off with taking a very careful history from the patient with the specifics of their sleep problem and how well they sleep, identifying any sleep-related problems. From there, we pursue additional examinations to determine the basis of their initial complaint.

The other half of the patients I see do not necessarily present with a sleep complaint. Rather, they present with memory complaints and other types of problems and complaints that are then determined to be related to sleep disturbances.

AJMC®: Are there any unmet needs in treating insomnia in older adults?

AUERBACH: The medical profession does not pay enough attention to comorbid anxiety [in older adults], and as a

result, the condition is undertreated. In addition, many primary care providers are not addressing insomnia in their discussions with the patient. They avoid the discussion. Inquiring how a patient is sleeping, however, should be at the top of their list of questions. In a lot of ways [a patient's sleep quality] is a good indication of whether or not something is wrong with the patient. Many different medical issues can impact a patient's sleep, and addressing their sleep complaints can ultimately improve their quality of life. ♦

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