Behavioral interventions for insomnia: Theory and practice

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ABSTRACT

Insomnia is a general clinical term that refers to a difficulty in initiating or maintaining sleep. Insomnia is widely prevalent in the general population, especially in the elderly and in those with medical and psychiatric disorders. Hypnotic drug treatments of insomnia are effective but are associated with potential disadvantages. This article presents an overview of behavioral interventions for insomnia. Behavioral interventions for insomnia include relaxation training, stimulus control therapy, sleep restriction therapy, sleep hygiene, paradoxical intention therapy, cognitive restructuring, and other approaches. These are briefly explained. Research indicates that behavioral interventions are efficacious, effective, and likely cost-effective treatments for insomnia that yield reliable, robust, and long-term benefits in adults of all ages. Detailed guidance is provided for the practical management of patients with insomnia.

Key words: Behavioral interventions, cognitive behavior therapy, insomnia, sleep hygiene, sleep restriction, stimulus control

INTRODUCTION

Insomnia is the most common sleep disorder. Insomnia is a general clinical term that refers to the difficulty in initiating or maintaining sleep. It may present as an independent problem (primary insomnia) or as part of a coexisting medical or psychiatric condition (secondary insomnia). According to ICD-10,[1] nonorganic insomnia (F 51.0) is defined as a problem in initiating and/or maintaining sleep or the complaint of nonrestorative sleep that occurs on at least three nights a week for at least a month, and is associated with daytime distress or impairment. The diagnosis primary insomnia (307.42) in DSM-IV[2] is used to distinguish insomnia that is considered to be a distinct diagnostic entity from insomnia that is a symptom of an underlying medical and/or psychiatric condition. The DSM lists insomnia related to other Axis I or Axis II disorders as distinct from primary insomnia.

Primary insomnia is referred to as “psychophysiologic insomnia” in the international classification of sleep disorders-revised (ICSD-R) proposed by the American Sleep Disorders Association and endorsed by the American Academy of Sleep Medicine. The ICSD-R definition is more directly tied to the etiological underpinnings of the disorder and it suggests how insomnia is initiated and maintained. Psychophysiologic insomnia is described as “a disorder of somatized tension and learned sleep preventing associations that results in a complaint of insomnia and associated decreased functioning during wakefulness.”[3] “Somatized tension” refers to either the patient’s subjective sense of, or objective measures of, somatic hyperarousal while attempting to sleep. Somatic hyperarousal is characterized by peripheral nervous system activity which is commonly marked by increased muscle tension, rapid heart rate, sweating, and related symptoms. “Learned sleep-preventing associations” refer to the pattern of pre-sleep arousal that appears to be classically conditioned to the bedroom environment, where intrusive presleep cognitions, racing thoughts, and rumination are often taken as indicators of presleep arousal.[4]
MAGNITUDE OF THE PROBLEM

Insomnia is widely prevalent and is reported to occur in up to one-third of the adult population. Persistent sleep problems have been reported by 10-15% of adults. The prevalence of sleep problems among women and older adults is even higher. Although more than half of primary care patients may experience insomnia, only about one-third report this problem to their physicians and only 5% seek treatment. Despite the very high economic cost of insomnia in terms of lost productivity and accidents, the vast majority of persons with insomnia remain untreated. Two-thirds of patients with insomnia report a poor understanding of treatment options, and many turn to alcohol (28%) or untested over-the-counter remedies (23%).

Various psychological, behavioral, and biological factors have been implicated in the development and maintenance of insomnia as a disorder. However, the etiology of insomnia remains under investigation and is still not fully understood. Two types of treatment for insomnia have received adequate empirical support: hypnotic medications and cognitive behavioral interventions.

BEHAVIORAL INTERVENTIONS FOR INSOMNIA: CHRONOLOGY

Early psychological treatments for insomnia focused on primary insomnia. Application of behavioral therapeutic approaches in the treatment of insomnia began with interventions such as systematic desensitization, relaxation, hypnosis, biofeedback, and paradoxical intention, which targeted hyperarousal associated with insomnia. During the 1970s, stimulus control therapy for insomnia was introduced. In the late 1980s, a new behavioral intervention, sleep restriction, was introduced. Around the same time, the application of cognitive restructuring for dysfunctional beliefs related to insomnia was proposed and subsequently formalized and integrated into several multi-component treatments of insomnia.

Effective treatment of insomnia must address the cognitive and behavioral mechanisms that maintain insomnia. Therefore, the best practices of nonpharmacological treatments for insomnia target both dysfunctional attitudes and beliefs about sleep and maladaptive behaviors (increased time in bed) that maintain abnormal sleep patterns. In recent years, cognitive behavioral therapy for insomnia (CBT-I), which combines different behavioral therapies and cognitive therapy techniques, has emerged as preferred treatment for insomnia.

RELAXATION THERAPY

Relaxation therapy is based on observations that insomnia patients often display high levels of physiologic, cognitive, and/or emotional arousal, both at night and during the daytime. A number of formal relaxation therapies have been applied to insomnia since such therapies reduce the sleep-related performance anxiety and bedtime arousal common to this condition. This type of intervention may be most suitable for patients who characterize their insomnia as an “inability to relax” and/or for patients who present with multiple somatic complaints. Progressive muscle relaxation (PMR), autogenic training, and biofeedback are aimed at reducing somatic arousal (e.g., muscle tension). Biofeedback is a form of relaxation that provides sensory feedback (visual or auditory, either mechanically or with computers and amplifiers) to help patients learn how to control physiological parameters such as galvanic skin response or muscle tension in order to reduce somatic arousal.

Attention-focusing procedures such as imagery training or meditation seek to lower pre-sleep cognitive arousal (e.g., intrusive thoughts, racing mind). Abdominal breathing is often a component of various relaxation techniques, or it may be used alone. Relaxation therapy is useful for both sleep onset and sleep maintenance insomnia. Regardless of the specific relaxation strategy employed, treatment typically involves conducting specific treatment exercises, teaching relaxation skills, and regular practice with a trained professional over multiple treatment sessions. Most practitioners select the optimal relaxation method based upon which technique is easiest for the patient to learn, and most consistent with how the patient manifests arousal. Some patients, especially those with a history of panic disorder or performance anxiety, might experience a paradoxical response to relaxation techniques. If this occurs with one form of relaxation technique, other suitable techniques may be considered. A detailed discussion of the subject was provided by Perlis et al.

STIMULUS CONTROL THERAPY

Bootzin pioneered the use of stimulus control instructions as a behavioral treatment for insomnia. This set of instructions is designed to help the patient with insomnia to establish a consistent sleep-wake rhythm, strengthen the bed and bedroom as cues for sleep, and weaken them as cues for activities that might interfere with sleep. The stimulus control instructions, as described by Bootzin et al., address the following points: when to go to sleep; what activities are permitted or disallowed when in bed; what to do if sleep is not attained within a reasonable period of time; when to rise in the morning; and daytime napping.

Stimulus control therapy originated from an operant learning analysis in which falling asleep is conceptualized as an instrumental act intended to produce reinforcement (i.e., sleep). Stimuli associated with sleep become
discriminative stimuli for the occurrence of reinforcement. Difficulty in falling asleep, or in returning to sleep after awakening, may be due to inadequate stimulus control.[30,31] The operant conditioning goals of stimulus control are to strengthen sleep-compatible associations with the bed and bedroom environment and to remove sleep incompatible ones; the classical conditioning goals are to break the association between the bedroom and insomnia. The stimulus control instructions decrease the bed and bedroom as cues for arousal and re-establish the bed and bedroom as strong cues for sleep. They additionally promote a more regular circadian sleep–wake cycle.

It is also necessary to caution the patients not to “clock-watch,” an action that reinforces wakefulness. Instead, patients should rise from bed if they think that 15-20 minutes has passed, without sleep, after retiring. One advantage of this instruction is that patients learn to better identify what signs (e.g., yawning, tired eyes, inability to keep eyes open, nodding off) manifest when they are actually sleepy rather than merely fatigued.[32]

**SLEEP RESTRICTION THERAPY**

The longer a person stays awake, the less likely it is that he will be able to remain awake, and the more likely he is to start to feel sleepy. This increasing sleepiness is known as the homeostatic sleep drive. Spielman et al.[18] developed sleep restriction therapy for insomnia based on this biological drive. It is a behavioral technique which is essentially a systematic, controlled, partial form of sleep deprivation designed to consolidate sleep rapidly and then gradually increase the scheduled time allotted for sleep when adequate sleep efficiency has been achieved. The goal of sleep restriction is to regulate the sleep-wake cycle by tailoring the time spent in bed to the patient’s true sleep need.[18] It begins by calculating average total sleep time, which is accomplished by completing sleep logs that record the duration of time in bed and the total duration of time spent sleeping. If a person with insomnia stays in bed for 9 h per night but is only sleeping for 6 h per night, he is advised to limit the time in bed to 6 h, which is his “sleep window.” Therapy seeks to consolidate sleep such that time passed in bed is spent sleeping rather than awake. The sleep efficacy ([total sleep time/total in bed] × 100) goal for a person with insomnia should be around 85%.

Sleep opportunity is never restricted to less than 5 h because, otherwise, the patient may suffer excessive daytime drowsiness. If a person’s sleep efficacy is greater than 90% in any week, he or she is given an additional 15-20 min of time each night. Weekly sleep efficacy of less than 80% requires a decrease in sleep window by 15-20 min.

The consistent bedtime and wake time required by this procedure helps re-entrain and strengthen circadian rhythms which are dysregulated with the irregular sleep schedules common to people with insomnia. Sleep restriction therapy is generally combined with stimulus control therapy or other forms of therapy. From a classical conditioning standpoint, sleep restriction increases the establishing operation of sleepiness, which makes the individual more likely to fall asleep when he goes to bed.[32]

**SLEEP HYGIENE EDUCATION**

This is another behavioral intervention that is primarily psychoeducational in nature, wherein patients are provided instructions about healthy sleep habits.[33] Sleep hygiene involves educating the patient about health practices such as diet, exercise, and substance use, and about environmental factors such as light, noise, temperature, and bedding, that is, important personal and environmental factors that can be positive or negative for sleep. Sleep hygiene recommendations have been listed by the National Institute of Health,[34] Perlis and Youngstead,[35] Perlis et al.[36] and others. Although poor sleep hygiene may not be the sole cause of insomnia, it can perpetuate insomnia. Therefore, sleep hygiene education is a necessary addition to other established known beneficial treatments.[36]

**PARADOXICAL INTENTION THERAPY**

Paradox has been part of psychological theory and practice for long. Frankl’s[16] concern that patients took control of their symptoms arose from an existential philosophy. Paradoxical intention is concerned with increasing the frequency of responses that already occur too often. In other words, paradoxical intention involves prescribing the symptom. This intervention is thought to be suitable for insomnia when there is intense preoccupation about sleep, sleep loss, and its consequences.[37] It is based on the concept that performance anxiety prevents proper sleep. Paradoxical intention reduces performance anxiety about falling asleep by instructing patients to do the opposite - get into bed and stay awake. When the individual with insomnia engages in the most feared behavior, staying awake, performance anxiety related to trying to fall asleep slowly diminishes. Paradoxical intention may be included as an element of multi-component CBT.

**COGNITIVE THERAPY**

There are several forms of cognitive therapy for insomnia. These can involve didactic focus, paradoxical intention, distraction and imagery techniques, and cognitive restructuring. There is an attempt to alter dysfunctional attitudes and beliefs about sleep, the consequences of which can be insomnia. Cognitive therapy also addresses catastrophization about the consequences of poor sleep. Patients are helped to reconceptualize the realities of their beliefs; this, in turn, helps decrease the sleep-interfering anxiety that generally increases as bedtime approaches.[29]
COGNITIVE BEHAVIOR THERAPY FOR INSOMNIA

Cognitive behavior therapy for insomnia (CBT-I) refers to combinations of behavioral techniques and conventional cognitive restructuring, and has evolved as a multi-component treatment approach. According to Pigeon, CBT-I is based on (a) the application of both operant and classical conditioning paradigms in the form of stimulus control instructions; (b) the correction of sleep-interfering behaviors through sleep hygiene education; (c) the recognition and reduction of hyperarousal precursors of insomnia; (d) the improvement of circadian and sleep homeostasis regulation of sleep through sleep scheduling and limited, partial sleep deprivation; and (e) the use of cognitive therapy. The individual components of CBT-I include psychoeducation, behavioral strategies, cognitive therapy, and relaxation training. Whereas these can be delivered separately as monotherapies, multicomponent CBT-I is the preferred approach.

EVIDENCE FOR THE EFFICACY OF COGNITIVE BEHAVIORAL INTERVENTIONS FOR INSOMNIA

Recently, the American Academy of Sleep Medicine updated practice parameters for the psychological and behavioral treatment of insomnia in adults. In this document, a treatment was designated as a standard treatment if it had the highest level of empirical validation (e.g., at least two placebo-controlled randomized clinical trials). If the treatment was effective but had a lower level of empirical validation (e.g., only one placebo-controlled randomized clinical trial along with clinical case studies, waitlist control studies, etc.), it was designated as guideline treatment.

Although pharmacotherapy has been found to be useful for acute insomnia, psychological interventions which mainly include cognitive and behavioral interventions are considered better choices for primary insomnia, chronic insomnia, and insomnia comorbid with other psychological disorders and medical conditions. CBT-I, which combines different behavioral therapies and cognitive therapy techniques, has emerged as a preferred treatment for insomnia. Hypnotic medications for insomnia carry an advantage in that their benefits are immediate and often ensured. However, hypnotic medications can cause early morning hangover, daytime drowsiness, psychomotor impairment, cognitive impairment, and adverse consequences associated therewith. Hypnotic medications may also be associated with tolerance and dependence. Finally, hypnotics are effective only for as long as they are used, whereas once behavioral interventions are initiated and become a lifestyle practice, their efficacy can be expected to persist. This may be why long-term outcomes of insomnia tend to be better with behavioral interventions than with pharmacological interventions.

Relaxation therapy for insomnia includes several relaxation methods. Most research evidence favors PMR as a treatment for insomnia. This treatment has been found to be more effective than placebo, waitlist, and no-treatment controls. Biofeedback as a form of relaxation therapy has been identified as a guideline treatment for insomnia as only one placebo-controlled trial has been performed to date and the findings of two waitlist control studies were mixed. Biofeedback is often paired with some form of relaxation exercise such as PMR. The results are comparable to PMR alone. This makes it difficult to make a case for biofeedback, given that it involves expensive equipment.

Stimulus control therapy has been found to be the most effective single treatment and is recommended as a standard treatment for chronic insomnia. Whereas, sleep restriction therapy is also found to be efficacious and the AASM lists it as a guideline treatment because fewer RCTs have examined it as a single treatment (most behavioral intervention studies combined stimulus control with sleep restriction, making it impossible to determine the efficacy of sleep restriction, by itself). It is worth noting, however, that sleep restriction has effect sizes equal to that with stimulus control therapy.

Research on paradoxical intention has produced mixed results, with four studies showing it to be more effective than controls and two studies finding no advantage. Paradoxical intention is rarely recommended over more empirically supported methods or methods included in multimodal therapy, but may be useful when patients do not benefit from other methods.

Sleep hygiene has been found to be ineffective as monotherapy. Whether sleep hygiene is effective when combined with other approaches cannot be determined from the available data. Sleep hygiene, therefore, is perhaps best delivered in an interactive and coexperimenter approach where the therapist and patient review each of the sleep hygiene items, discuss how each item is related to sleep, and consider whether any of the items apply to the patient. The simplicity of sleep hygiene may explain why it is the technique with which most nonspecialists are familiar, and why it is often the only treatment offered to patients; and its failure in monotherapy may explain why clinicians advising sleep hygiene often draw an inappropriate conclusion that behavioral treatments are ineffective for insomnia.

A large number of studies have been conducted to examine whether cognitive behavioral therapy for insomnia (CBT-I) can work under controlled conditions (i.e., efficacy studies) as well as whether CBT-I does work in applied settings (i.e., effectiveness studies). The efficacy and effectiveness research provides strong support for CBT-I. More than 50 randomized controlled clinical trials have shown that
CBI-I results in reliable and robust improvements across different subjective and objective measures of sleep disturbance.\(^{[54]}\) While the individual components of CBT-I (psychoeducation, behavioral strategies, cognitive therapy, and relaxation training) can be delivered as monotherapies, multicomponent CBT-I is the preferred approach.\(^{[55]}\) Additionally, cognitive behavioral interventions are as effective as pharmacological treatments in the short term and more effective in the long term.\(^{[55,44,56,57]}\) Meta-analyses also show that cognitive and behavioral therapies are significantly more effective than placebo in improving sleep in patients with primary insomnia.\(^{[20,50]}\) Cognitive and behavioral approaches are also effective in the elderly.\(^{[58-60]}\) Whereas research on CBT for insomnia secondary to medical conditions is limited, data suggest that CBT is efficacious for insomnia secondary to both chronic pain and breast cancer.\(^{[53]}\)

**CONCLUSION**

Insomnia is widely prevalent in the general population and most patients with insomnia remain untreated. Hypnotic drugs and CBT interventions are both effective intervention with the latter associated with several advantages over the former. CBT-I is a multi-component cognitive-behavioral treatment approach and has received sufficient validation by researchers and clinicians. Available data suggest that CBT-I is an efficacious, and likely cost-effective treatment for insomnia that yields reliable, robust, and long-term benefits among younger as well as older adults. The delivery of formal CBT-I will require professional training on the part of the therapist. However, simple behavioral procedures and techniques can be taught to most patients with insomnia, and these are presented in the Appendix.\(^{[61]}\)

**APPENDIX: GUIDELINES FOR SLEEPING BETTER AT NIGHT**

The best way to treat insomnia is to identify and remedy the cause: medical, psychiatric, or other. This should be done wherever possible. It is also important, and helpful, to implement behavioral measures; these are described below. None of the suggestions here is an absolute requirement; however, most are based on good scientific evidence and are, therefore, best adhered to. Importantly, the guidelines need to be tailored to individual contexts; what is appropriate for one patient may not be suitable for another.

**During the Day**

Do not nap during the day unless you have good reason to believe that doing so improves the quality of your life. If you do nap during the day, you must recognize that your nighttime sleep requirement will be correspondingly shortened.

**Before bedtime**

Taper off your physical activity as you approach your bedtime; otherwise, you will be too alert to sleep. Therefore, you should not exercise vigorously for 4-6 h before you retire; you should not involve yourself in any moderate exertion for 2-4 h before you retire.

**Note.** Simple stretching or a little walk around the house can be relaxing. The guiding principle is that you should be made more relaxed and not more alert by whatever you do. If whatever you do makes you feel flushed and breathe heavily, or makes your heart beat faster, it will probably keep you awake for longer.

**Note.** Moderate physical fatigue can be relaxing; excessive physical fatigue can be counterproductive because it could result in aches and pains that interfere with sleep. Exercise too late in the evening could result in arousal that persists and prevents sleep at night.

**Note.** Sexual activity is an exception to the rule because its culmination results in physical and mental relaxation.

Do not consume so much fluid during the late evening that you need to rise in the night to empty your bladder. Avoid alcohol intake and smoking in the late evening; alcohol and nicotine are known to result in disturbed sleep. Avoid eating or drinking much during the hour or two prior to retiring; in particular, avoid stimulating foods (e.g., chocolate, especially dark chocolate) or beverages (e.g., coffee, tea, cocoa, cola drinks). However, do not go to bed hungry.

**Note.** A glass of warm milk or a carbohydrate snack may, however, help you feel drowsy.

Do not have a cold bath during the hour or two before retiring; this will make you more alert. Likewise, do not have a hot bath during the hour or two before retiring; your body needs to feel cool if you are to fall asleep. Bathing is, itself, a physical activity which may make you more active and alert.

**Before bedtime, avoid laughing, joking, speaking on the telephone, or any social activity that gives you a lift or makes you think more. Likewise, avoid any debate, argument, or any social activity that makes you irritable or angry. And do not listen to loud, peppy music because of its activating effects.**

**Note.** Light, desultory conversation with a family member before bedtime can be relaxing.
Avoid mental activity before retiring. Watching an entertaining or engrossing program on television, doing crosswords, playing chess, or concentrating on any other task can make you more alert.

Note. This may not apply to activities that you consider work. For example, attending to your accounts or other paperwork may tire you enough to make you look forward to closing up and going to bed.

Avoid doing anything that may make you alert or annoyed before bedtime. Do not think about emotionally disturbing matters. If you find yourself tense, alert, or irritable, do something that is calming or mentally relaxing in the 5-20 min before you retire. This includes meditating, praying, reading, or pottering around the house, or engaging in a relaxing conversation or any other activity which helps you unwind.

Note. Such relaxing activities are a useful routine but become especially important if you are tense and edgy as a result of the events of the previous hours or the day.

Avoid exposure to bright lights for the 5-10 min or so before you retire. This includes looking at the television. Bright light will tend to make you more alert.

Avoid taking sleeping pills unless you absolutely must. Sleeping pills are habit-forming.

Note. If you slept poorly during the previous night you will tend to sleep poorly during the present night as well. This is because your body can get into a rhythm of sleeping less even though sleeping less leaves you tired and irritable. Furthermore, loss of sleep on a previous night can make you too tense and too tired to be able to relax sufficiently to be able to sleep easily on the present night. In such circumstances, the one-off use of a sleeping pill may sometimes be acceptable. It can break the rhythm of poor sleep to which your body has become accustomed.

Note. Melatonin normalizes biorhythms, cools the body, and promotes normal sleep. Melatonin is not a habit-forming drug. However, melatonin does not work well as a hypnotic for everyone.

At bedtime

Plan your day so that you are able to retire at approximately the same time every night. This will help your body get conditioned to feeling sleepy at that time each night.

Retire only when you are tired; if you go to bed when you feel wide awake, you will toss and turn and find it hard to fall asleep.

If you feel sleepy, go to bed soon. If you postpone retiring, your body will slowly start becoming more alert, and you will find it harder to fall asleep.

Preferably, sleep in the same place every night. This will help your body get conditioned to feeling sleepy when you head for your bed. If you change your sleeping arrangements frequently, your body may take some time to adjust to the change before you begin to feel sleepy.

Reduce environmental stimulation in your sleep zone. Use minimum lighting (or none at all), avoid noise, disconnect your phone, and do whatever else is necessary to ensure that there is no disturbance.

Note. Some persons find it easier to fall asleep if there is soft music playing. Others find that music captures their attention and prevents them from sleeping.

If disturbance due to traffic noise, festival celebration, or any other source is inevitable, it is important that you adopt an accepting attitude much as you would accept the sound of a ceiling fan. Allow the sound to recede into the background. If you resent the sound, you will begin to pay attention to it and you will not be able to sleep. Or, if you resent it, your anger may not allow you to sleep.

Ensure that your pillow and bed are comfortable. Ensure that you have an adequate number of sheets and blankets for cold weather, or that the cooling arrangements are adequate during summer.

Take measures to minimize pests such as mosquitoes.

When in bed, avoid thinking about matters that provoke mental or emotional activity. Thus, do not address an engrossing problem, relive an exciting happening, brood over an unhappy event, think about an irritating or anxiety-provoking issue, etc. Just think about pleasant or peaceful matters, meditate, or pray.

Do not concentrate on trying to fall asleep, worry that you are not falling asleep, or time yourself to falling asleep. Do not periodically check the time. Do not look at the clock if you are awake at night. This will only make you feel alert, frustrated, or annoyed.

Ways in which you can blank out thoughts that keep you awake include the following.

(1) Direct your attention to restful sounds in your environment, such as distant traffic noise
(2) Visualize a peaceful scene and imagine yourself in it
(3) Focus on the air moving in and out of your lungs
(4) Systematically relax your body, part by part, and imagine your body sinking heavily into the mattress
Start with your toes, then your legs, then your thighs, and move upwards, gradually, till you reach your head. If you sit or stand in the same place for any length of time, you will begin to feel restless. Likewise, if you are unable to fall asleep within a reasonable period of time, you will begin to toss and turn and feel irritable and restless. So if you cannot fall asleep within 15-30 min, the moment you begin to feel restless, get up. Read or listen to soothing music in a dimly lit environment and return to bed only when you feel tired. Repeat this process as many times as it takes you to feel sleepy and fall asleep.

If you awake in the middle of the night and have to get up, avoid bright lights, physical activity, mental activity, or anything that makes you alert.

**General suggestions**

**Rise**

Rise at the same time every morning, preferably at a reasonable hour, irrespective of the length of time for which you have slept during the night. If you did not sleep well the previous night, the loss of sleep will tend to make it easier for you to fall asleep on the present night. However, if you sleep late into the morning, you will tend to find it difficult to sleep at night.

Do not use your bed for activities other than sex or sleeping; if you do, you may become conditioned to feeling alert in bed.

Adopt stress-management and time-management strategies to reduce the anxiety or other emotional disturbances associated with your lifestyle. Likewise, take up hobbies and recreational pursuits that help you unwind. Make sure that you receive treatment for any medical, psychiatric, or other conditions that may interfere with your sleep. Check with your doctor whether any of the medicines that you are receiving interfere with sleep; if yes, ask whether these can be changed.

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Source of Support: Nil, Conflict of Interest: None declared