

Recharge Overview - Part I

Recharge is different from other areas of self-care in the Circle of Health. Sometimes, rather than requiring that a person “do something,” enhancing health may involve *not* doing something. How might stillness – or taking a pause – fit in? Recharge can involve taking a break, or a vacation. In addition, a major focus for Recharge in many Integrative Health plans is sleep, which is essential to good health. This overview builds on the material in Chapter 9 of the [Passport to Whole Health](#), specifically focusing on how sleep is influenced by all of the areas of the Circle of Health.

Key Points

- Good sleep has a multitude of health benefits; conversely, insomnia can be quite harmful to health and can contribute to decreased lifespan and risk of multiple chronic diseases.
- As you work with people to help them improve their sleep, there are many options available. Goals related to self-care, such as dietary changes or creating activity plans can help, as can working with stress using various mind-body tools, including those offered by Cognitive Behavioral Therapy for Insomnia (CBT-I).
- Professional care can also play an important role when it comes to Recharge. Dietary supplements (several are discussed), acupuncture, and pharmacotherapy all have their place, as do a number of other approaches.

Meet the Patient

Carl, a 62-year-old retired pilot, presents with complaints of poor sleep. His symptoms began when he started to fly on international routes and had to repeatedly deal with jet lag. He describes difficulty falling asleep and staying asleep. He occasionally has disturbing dreams relating to his service as an Air Force pilot Operation Desert Storm in his 20s. He has had a sleep study in the past, and it demonstrated mild obstructive sleep apnea, but he declined treatment with continuous positive airway pressure (CPAP).

Carl reports difficulty falling asleep unless he takes medication. He has tried multiple over-the-counter agents but feels groggy in the morning whenever he takes them. About three years ago, he was prescribed zolpidem 10 milligrams and initially found it to be effective. However, he has been using it essentially continuously for at least 18 months, and lately he has found it to be less effective. As a result, he has increased his dose to two tablets. His primary care physician has become concerned about the increased dose, and the pharmacist has expressed concerns about continued usage at this dose. Carl recently experienced a fall during a sleep-walking incident.

Carl lives with his wife in a small single-family home. He spends his time doing woodworking in his home shop. He consumes at least 12 cups of coffee daily, noting, “We always keep a pot on during the day.” He usually watches TV in the evening, when he may drink one to three beers. He typically falls asleep briefly in his recliner. He is very concerned about politics and will spend

several hours a day watching the news. In addition, he spends at least an hour each evening on the computer doing social-networking and related activities. He has a variable sleep schedule and watches TV in bed until he dozes off, but he is often awakened by the television between 3 and 4 a.m. He used to be an early riser, but now he sleeps until 8 or 9 a.m., especially if he had a bad night of sleep the night before. He does not exercise regularly and has gained 30 pounds in the past year. He is often tired and irritable during the day. He feels depressed and states, “I can’t believe I let it get so bad.”

Carl is asked to complete a Brief PHI. His Vitality Signs are all in the mid-range:

Physical Well-Being				
1	2	3	4	5
Miserable				Great
Mental/Emotional Well-Being				
1	2	3	4	5
Miserable				Great
Life: How is it to live your day-to-day life?				
1	2	3	4	5
Miserable				Great

His Mission, Aspirations, and Purpose (MAP) answers focus on having enough energy to be there for his loved ones:

**What is your mission, aspiration, or purpose? What do you live for?
What matters most to you?**

Write a few words to capture your thoughts:

I want to have the energy to do all the things I want to do. My wife and all of my family members are important to me. I want to be able to be there for people who need me. I want to be able to bring my best effort into every part of my life.

Carl has a variety of ratings for “Where I am Now” relative to “Where I want to be” on the second page of his PHI. He makes it clear that sleep is where he wants to focus. He rates himself a 1 (current state) out of 5 (desired state) in terms of Recharge.

The final question on Carl’s Brief PHI is not subtle either:

Are there any areas you would like to work on? Where might you start?

Sleep, sleep, sleep. I want to get off the medication, if I can, because sleepwalking scares me. I want to get rid of the nightmares. I will do anything to get more rest and to stop the nightmares. I need peace.

Introduction

If there's a secret to a good night's sleep, it's a good day's waking.¹

—Rubin Naiman

The purpose of this review is to build on Chapter 9, “Recharge: Sleep & Refresh” in the [Passport to Whole Health](#). How is it possible to help someone like Carl find the peace he wants? Figure 1 shows several potential topics you might consider if you zoom in on the Recharge circle in the Circle of Health.

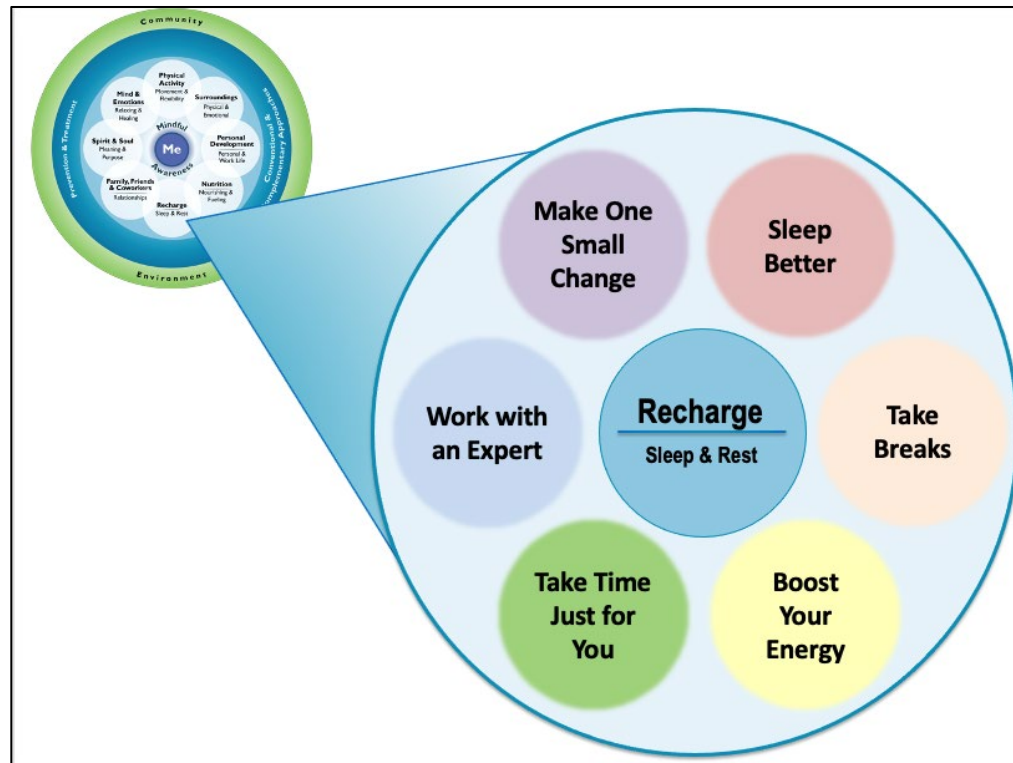


Figure 1. Subtopics within the Recharge Circle of Self-Care

This overview will focus on the “Sleep Better” and “Work with an Expert” circles, providing an evidence-informed look at how the Whole Health approach can support sleep.

What is insomnia?

Insomnia is defined as inadequate sleep duration or nonrestorative sleep. In surveys, insomnia may be defined by questions such as, “Do you have difficulty falling asleep?” or “Do you have difficulty staying asleep?” In the sleep literature, insomnia is a term that often is used to describe long sleep latency; people with insomnia take longer to fall asleep, they have frequent awakenings, or both.² The most essential element in the care of patients with sleep complaints is the subjective data they provide, and the most commonly used research scale for subjective evaluation of insomnia is the Pittsburg Sleep Quality Inventory (PSQI)³, which can be a useful part of the Whole Health Assessment when you are working with someone who wants to focus on Recharge.

Objectively, studies of people with insomnia show that they have modest increases in how long it takes them to fall asleep compared to people without insomnia. They spend more time awake during the night, and they have slight decreases in total sleep time when compared to controls.⁴ In extreme cases, patients may complain of being awake when physiologically they are actually asleep. This is known as sleep state misperception.⁴

Types of Insomnia

Insomnia can be grouped into three different types depending on the duration of the problem: transient, acute and chronic.

Transient Insomnia

Transient periods of sleep disturbance associated with situational stress are a universal human experience. The annual incidence of transient situational insomnia is estimated to be as high as 85%.²

Acute Insomnia

When insomnia persists more than a few nights, but less than a month, it is classified as acute insomnia. Severe acute insomnia is a significant risk factor for the development of chronic insomnia, but it is unclear if intervention in acute insomnia, including behavioral and pharmacological means, can reduce the risk of the development of chronic insomnia.⁵

Chronic Insomnia

Chronic insomnia is defined as insomnia that persists for more than a month. Chronic insomnia affects an estimated 9% to 30% of the general population.²

Insomnia Complications

Cardio-metabolic disease

Chronic insomnia has been shown to be a risk factor for a multitude of cardio-metabolic conditions including obesity, diabetes, hypertension, heart-disease and stroke.⁶⁻⁸

Mood and Depression

While irritability is a common complication of acute or short-term insomnia, insomnia can be a marker for more serious psychiatric illnesses. A prodromal period of insomnia is a robust predictor of incipient depression.⁹ In patients with depression, insomnia is associated with a greater risk of relapse and a decreased response to treatment.¹⁰ Cognitive behavioral therapy for insomnia (CBT-I) has been shown to significantly improve response rates to

pharmacotherapy for depression and helps get at the root causes of it, as the patient and therapist work together to problem-solve around why sleep is poor and how it can be improved.¹¹ CBT-I is discussed more below.

Accidents

Insomnia is associated with 7.2% of all workplace accidents and 23.7% of the costs of workplace accidents, resulting in a combined yearly expense of \$31.1 billion dollars.¹²

Suicide

In a study of sleep and suicide risk in, poor sleep quality was significantly associated with suicidal ideation.¹³ “Short sleepers” were more likely to have attempted suicide in the preceding year. The combination of insomnia and alcohol use was particularly predictive of suicide risk. A 2012 study showed that sleep disorder prevalence correlated with a higher risk of suicidal ideation and behavior than did depression or hopelessness.¹⁴

Author(s)

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References

1. Naiman R. Insomnia. In: Rakel D, ed. *Integrative Medicine*. 3rd ed. Philadelphia, PA: Elsevier Saunders; 2012:65-76.
2. Roth T. Insomnia: definition, prevalence, etiology, and consequences. *J Clin Sleep Med*. 2007;3(5 Suppl):S7-10.
3. Buysse DJ, Reynolds CF, 3rd, Monk TH, Berman SR, Kupfer DJ. The Pittsburgh Sleep Quality Index: a new instrument for psychiatric practice and research. *Psychiatry Res*. 1989;28(2):193-213.
4. Rosa RR, Bonnet MH. Reported chronic insomnia is independent of poor sleep as measured by electroencephalography. *Psychosom Med*. 2000;62(4):474-482.
5. Ohayon MM. Epidemiology of insomnia: what we know and what we still need to learn. *Sleep Med Rev*. 2002;6(2):97-111.
6. Cappuccio FP, Miller MA. Sleep and cardio-metabolic disease. *Curr Cardiol Rep*. 2017;19(11):110.
7. Khan MS, Aouad R. The effects of insomnia and sleep loss on cardiovascular disease. *Sleep Med Clin*. 2017;12(2):167-177.
8. St-Onge MP, Grandner MA, Brown D, et al. Sleep duration and quality: impact on lifestyle behaviors and cardiometabolic health: A scientific statement from the American Heart Association. *Circulation*. 2016;134(18):e367-e386.
9. Franzen PL, Buysse DJ. Sleep disturbances and depression: risk relationships for subsequent depression and therapeutic implications. *Dialogues Clin Neurosci*. 2008;10(4):473-481.
10. Troxel WM, Kupfer DJ, Reynolds CF, 3rd, et al. Insomnia and objectively measured sleep disturbances predict treatment outcome in depressed patients treated with psychotherapy or psychotherapy-pharmacotherapy combinations. *J Clin Psychiatry*. 2012;73(4):478-485.
11. Manber R, Edinger JD, Gress JL, San Pedro-Salcedo MG, Kuo TF, Kalista T. Cognitive behavioral therapy for insomnia enhances depression outcome in patients with comorbid major depressive disorder and insomnia. *Sleep*. 2008;31(4):489-495.



12. Shahly V, Berglund P, Coulouvrat C, et al. The associations of insomnia with costly workplace accidents and errors: Results from the America Insomnia Survey. *Arch Gen Psychiatry*. 2012;69(10):1054-1063.
13. Chakravorty S, Grandner MA, Mavandadi S, Perlis ML, Sturgis EB, Oslin DW. Suicidal ideation in veterans misusing alcohol: relationships with insomnia symptoms and sleep duration. *Addict Behav*. 2014;39(2):399-405.
14. Ribeiro JD, Pease JL, Gutierrez PM, et al. Sleep problems outperform depression and hopelessness as cross-sectional and longitudinal predictors of suicidal ideation and behavior in young adults in the military. *J Affect Disord*. 2012;136(3):743-750.