

CASE A

Identifying Information and Chief Complaint:

Patient is a 68 year old female who has a chief sleep complaint of difficulty maintaining sleep with consequential increased anxiety.

History of Present Illness:

She reports that her sleep and anxiety issues have been present for about 1.5 years with no clear precipitant. She reports some previous sleep and anxiety issues about 10 years ago when her partner had a chronic illness and then passed away. Otherwise, she has been mostly a good sleeper with only a tendency toward lighter sleep. In terms of past treatment, she has tried lorazepam, stretching prior to bed, and going to bed later. These strategies have been helpful, and she continues with each of them, but she would like to see further improvement. In terms of current treatment goals, she would like to have less difficulty staying asleep, feel less anxious, and eventually taper off of lorazepam.

She currently sleeps alone and finds her mattress comfortable. She states her bedroom is quiet, dark, and cool. In terms of her current sleep schedule, she goes to bed around 11pm and falls asleep quickly. She wakes up 2 to 3 times a night. She often notes waking up due to nocturia. She takes lorazepam (0.75 mg) when she wakes up for the first time, which helps to decrease the length of her awakenings in the first part of the night. However, she has concerns about taking this medication long-term. She also has concerns for what she will do if it stops working. When having difficulty sleeping at night, she stays in bed and tries to sleep. She sometimes finds herself worrying in bed. She wakes up between 6-7am and gets up about 30 minutes later. She does not nap or doze during the day.

She denies any loud snoring, gasping/choking during sleep, or witnessed apneas. She endorses some daytime sleepiness when doing more sedentary activities during the day like reading. She denies any odd sensations in her legs in the evening or when going to bed. She denies an advanced or delayed sleep pattern. She denies frequent nightmares. In terms of family history, she reports that her mother also had insomnia.

She described her mood as "stable". She states sleep difficulties and daytime consequences are her biggest stressors. She endorses worry during the day and at night as noted above, but mostly sleep-focused worry. She does not endorse any other psychiatric symptoms.

Psychiatric History:

Medication trials: Only lorazepam prescribed by her primary care provider

Psychotherapy: Yes, 20 years ago for depression related to divorce

Hospitalizations: None

Emergency Department Visits: None

Past Suicidal Attempts: None

Psychiatric Family History: sister with depression

Medical History: hypertension, hypothyroidism

Medications: amlodipine 2.5 mg, atenolol 25 mg, lorazepam 1 mg, levothyroxine 50 mcg

Habits: no caffeine, tobacco, alcohol, or illicit drug use; no history of misusing prescription medication

Social History:

Patient grew up in rural Illinois with her parents, 2 brothers, and 3 sisters. She notes a healthy, stable childhood. She has been married once, but marriage ended in divorce 20 years ago. She was also in a significant relationship with a partner who became ill and passed away approximately 10 years ago. She identifies one brother and several friends as her main supports. She works part-time and has no financial issues.