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Case Report

Tackling Insomnia in Everyday Clinical Practice

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Abstract

Insomnia is defined as a condition in which a person finds it difficult to fall or stay asleep. Basically, classified as acute (short-term, days to weeks) and chronic (long-term 3+ months, or 3+ nights/week) types based on duration of suffering. It is a health disrupting condition, less often help sought professional help and when sought is under diagnosed despite leading to high healthcare utilization. It is more common in women, the elderly, young children and those with co-existing mental or physical ill-health or sedentary life. Chronic Insomnia's outcomes include decreased quality of life, impairment in daytime functions, increased workplace accidents and production. Major risk factors for Insomnia include i) Psychiatric issues like depression & anxiety disorders, Parkinson's disease & post-traumatic stress disorder (PTSD) ii) physical causes like chronic pain, cardiovascular diseases, obstructive sleep apnoea, metabolic disorders and other sleep disruptors are thyroid dysfunction, GERD & restless leg syndrome iii) Social / Lifestyle causes like Shift work, more exposure to screen like TV or mobile phones, lower socio-economic status, and sedentary lifestyle. Primary health care provider or family Physicians come across more cases in routine clinic. They must make all out efforts to improve sleep quality/duration & reduce daytime functions impairment. The key treatment approaches practices are: 1) non-pharmacological management mainly Cognitive Behavioural Therapy for Insomnia (CBTI) through education, stimulus control, sleep restriction, & cognitive restructuring- first-line treatment 2) Pharmacotherapy for short-term management or if CBT- is ineffective 3) A combined approach will be the best option in general practice.

Materials & Methods: This article is an attempt to consolidate the approaches to treat different causes of Insomnia taking anecdotes of 6 cases handled by general practitioners in smaller settings and 2 referrals to tertiary care /Mental health hospitals.

Abbreviations:

depression & anxiety disorders, Parkinson's disease, PTSD =post-traumatic stress disorder, CBTI = Cognitive Behavioural Therapy for Insomnia, Benzodiazepines or Sedatives, Non-benzodiazepine Hypnotics, Melatonin Agonists

Kew Words: sleep; insomnia- acute & chronic; onset insomnia; maintenance insomnia.

Introduction

Insomnia is linked to decreased quality of life, impairment in daytime functions, increased workplace accidents, & high healthcare utilization. It is defined as a condition in which a person finds it difficult to fall or stay asleep. It is more common in women, the elderly, young children and those with co-existing mental conditions [1]. Insomnia is a highly prevalent, less often consulted and when consulted, underdiagnosed condition affecting health and quality of life of all individuals as per the literature search. In my personal experience as a family physician for last 58 years and public Health researcher for about 40 years, it affects roughly 10% of the adult population with chronic symptoms, & another 50% experience intermittent symptoms. About 30% of my patients and community surveys subjects reported at least one symptom of insomnia, while 15% reported daytime work capacity impairment. Prevalence increased with age and is higher in women than in men by about 25% (1.4 vs 2%). Insomnia often becomes chronic course, with about 40% persistence rate over a 5-year period [1,2]. Major risk factors for Insomnia include i) Psychiatric issues like depression & anxiety disorders, Parkinson's disease & post-traumatic stress disorder (PTSD) ii) physical causes like chronic pain, cardiovascular diseases, obstructive sleep apnoea, metabolic disorders and other sleep disruptors are thyroid dysfunction, GERD & restless leg syndrome iii) Social/Lifestyle causes like Shift work, lower socio-economic status, and sedentary lifestyle [2,3].

Insomnia is classified by duration into acute (short-term, days to weeks) and chronic (long-term 3+ months, or 3+ nights/week) types. Acute insomnia often stems from stress or life changes, while chronic insomnia is usually linked to underlying medical, mental health, or substance abuse or screen-

time-related issues. Clinicians also recognize Insomnia as i) Onset Insomnia where the complaint is difficulty in falling asleep. ii) Maintenance Insomnia in which after initial falling sleep, it is difficult to stay asleep or wakes up too early [2]. As a primary health care provider or family Physicians come across more cases in routine clinic and must make all out efforts to improve sleep quality/duration and reduce daytime impairment as a primary goal of treatment. The key treatment approaches practices are: 1) non-pharmacological management mainly Cognitive Behavioural Therapy (CBT) through education, stimulus control, sleep restriction, & cognitive restructuring- first-line treatment 2) Pharmacological Management is used for short-term management or if CBT- is ineffective. A) Non-benzodiazepine Hypnotics, Zaleplon & Zaplon, B) Benzodiazepines, central nervous system (CNS) depressants known as sedatives, e.g., Diazepam (Valium), & Lorazepam (Ativan) C) Melatonin Agonists like Meloset, Noctura, Altonil and iii) General Advice & Hygiene iv) A combined approach will be the best option in general practice.

This article is an attempt to consolidate the approaches to treat Insomnia by general practitioners in smaller settings.

Case Reports:

Case 1. Metabolic and Nutritional Causes: A 91-year-old male with long-term insomnia presented with severe sleep maintenance issues, to my clinic. After taking history some basic investigations were got done. He was having electrolyte imbalances- hypocalcaemia, & hypokalaemia and severe vitamin D deficiency. Once they were resolved his sleep maintenance issue was resolved in a weeks' time.

Case 2. Comorbid Factors: A 66-year-old woman visited my clinic in January 2026 with complaints of experiencing sleep onset and maintenance insomnia. She also complained of increased daytime fatigue and reduced sleep quality linked to lifestyle stress and aging. Detailed examination revealed pallor, hypertension and a few investigations (ECG, Hb%, SPO2 and BP, Renal function tests and EF +60%) indicated Heart failure with Preserved Ejection Fraction (HFpEF). Standard CCF management was initiated, which included i) SGLT2 Inhibitors Empagliflozin tablet ii) ARNIs (Angiotensin Receptor-Neprilysin Inhibitors) - Sacubitril/valsartan iii) Beta-Blocker metoprolol succinate to avoid worsening heart block or fatigue iv) Mineralocorticoid Receptor Antagonists (MRAs) Eplerenone was used with strict monitoring of potassium and renal function v) Furosemide diuretic was used for symptom relief and to maintain euvolemia. In women with EF >50%, treatment focussed on diuretics for congestion, SGLT2 inhibitors (which show benefit in HFpEF), and strict blood pressure control. In women with EF >50%, treatment focuses on diuretics for congestion, SGLT2 inhibitors (which show benefit in HFpEF), and strict blood pressure control. Her CCF was managed well that led to resolve her sleep issue in about 2 weeks. Regular check-ups of renal function (creatinine) and electrolytes (potassium) were done, as she was on ARNI & MRA. After recovery she was advised to take Influenza and pneumonia vaccines and regular screening for frailty, cognitive impairment, and depression.

Case 3. Chronic Lifestyle-Related Insomnia: A 46-year-old woman with a history of executive-level work developed severe, chronic middle insomnia (waking 3+ times, 5+ nights per week) and daytime fatigue over 5 months, highlighting the impact of stressful, active lifestyles on all working day night. On weekends she had no such problem. Suggested to her to schedule her work such that an hour before dinner she stopped all official work and went for a walk with grownup children for half an hour walk and practice 4-7-8 sleep method. For the first 2 weeks she was prescribed Meloset (Melatonin Agonists) tablets an hour before bedtime and tapered over next 3 weeks. Over a period of next 4 months, she got used to changed routine and now is not having Insomnia.

Case 4. Nocturnal media use linked Chronic Insomnia in a teenager: A 13-year-old boy was brought to the authors clinic in July 2025 with the complaints of with chronic insomnia and increased daytime sleepiness, disrupting his attention in the school resulting in steep fall in academic performance in 2025-25 compared to previous years. A detailed history revealed insomnia's link to excessive nocturnal media use. The author alerted the parents and suggested a restriction on digital device usage after 9 pm led to a significant improvement in the sleep duration with no adverse event over 4 months. Throughout the 16-week treatment period, the total sleep time of the patient normalized, and the daytime sleepiness problem was resolved and scholastic performance returned to previous year's level.

Case 5. Insomnia in a Web-Developer: Anand a 44-year-old web developer consulted the author with complaint of Insomnia over last 6 month. Detailed history indicated that long-term job stress and irregular, long hours resulted in "sleep work"—dreaming about work & inability to disconnect, ultimately hindering career advancement and causing persistent insomnia. A simple counselling with initial management of sleep problem with a Non-benzodiazepine Hypnotic, stopping digital exposure after 0900 PM and the 4-7-8 sleep method could get him rid of the problem in about 6 weeks' time.

Case 6. Healthcare Professionals & Shift Work: Three young nurses in their early 20's of a tertiary care hospital approached the author for a certificate to relieve them from Night duty. They reported since last 4 weeks they were on night duty of 0800 PM to 0800 AM with just one day break a week. On a detailed assessment they were with stress and appeared burnout due to sleep deprivation and high emotional demands. As they were working for almost 70-80 hrs of night duty every week and were a standard of working over 40 hours per week were prone for two-fold higher odds of insomnia.

Case 7. Insomnia due to Role Conflicts & Lack of Control: A Provincial services senior officer working for 8-10 hours day (compared to those working 35-40 hours), resulting in working >55 hours and his elder brother a teacher hardly working for 5-6 hrs day (less than 40 hrs a week). While the officer complained of Insomnia due to 3 high-stress roles, and the teacher complaining of lack of decision-making control as they were being drafted for non-teaching tasks by the district administration was finding it difficult to adjust to role conflicts combined with high demands created a "vicious circle" of stress-induced insomnia.

Case 8. Insomnia due to Digital arrest and loss of Money: A 55-year-old businessman consulted the author for Insomnia for 3-4 weeks in August 2025. The physical and mental examinations indicated no health issues, during the first week. He was put on benzodiazepine Hypnotics for a week. In his second visit he narrated that he recently lost about INR 50 Laksh due investment on web trading platform. The platform representative was forcing to invest more to recover the loss. The Cyber security is also investigating the case, and he is being summoned often for inquiry. Since he had no excess, money left, he was exploring to mobilize resource through loans. He was advised to stop trading and let the loss be absorbed instead of getting into much deeper debts. He had a few CBTI sessions in NIMHANS, Bengaluru. Fortunately, he took the advice positively and stopped trading since November 2025. Today he is more satisfied and his insomnia is resolved.

Discussions:

Insomnia is defined as a condition in which a person finds it difficult to fall or stay asleep. It is usually associated with significant impairment in daytime function & adversely affects the quality of life. It is more common in women, the elderly, young children and those with co-existing mental conditions like anxiety, depression or physical health conditions namely obstructive sleep apnoea, chronic pain, diabetes, cardiovascular disease, & Parkinson's disease and other sleep disruptors are thyroid dysfunction, GERD & restless leg syndrome. It is linked to decreased quality of life, increased workplace

accidents, & high healthcare utilization [1]. Insomnia is classified by duration into acute (short-term, days to weeks) and chronic (long-term, 3+ months, 3+ nights/week) types [2]. Acute insomnia often stems from stress or life changes, while chronic insomnia is usually linked to underlying medical, mental health, or substance-related issues.

Table Comparing

Acute & Chronic Insomnia

Characteristics	Acute Insomnia	Chronic Insomnia
Definition	Sleep problems that last less than 3 months.	Sleep problems that persist longer than 3 months.
Causative factors	A stressful life event such as death of a loved one or a change in a job.	Drugs, medical conditions, psychiatric problems, and stress.
Symptoms	Having a hard time falling asleep, waking up too early, and waking up often during the night.	A poor quality and duration of sleep, which causes daytime drowsiness.
Complications	Drowsiness and irritability during the day; poor work performance.	Drowsiness in the daytime and higher risks of accidents and developing medical conditions such as diabetes, heart disease, and hypertension.
Treatment	None or sleeping pills given for only a short time period.	CBT-I and prescription medicines that help with sleep.

DB Difference Between.net

Key Differences Between Acute and Chronic Insomnia

While Acute Insomnia Lasts for a few days to weeks and is caused due to Stress, traumatic events, work pressure, or environmental changes. It often resolves on its own or with improved sleep hygiene. On the other hand, Chronic Insomnia occurs at least three nights per week for three months or longer. The underlying causes include- anxiety, depression, chronic pain, medications, or other sleep disorders. It usually requires professional intervention, either Cognitive Behavioural Therapy for Insomnia (CBT-I) or pharmaco- therapy.

Some Clinicians describe Insomnias as i) Onset Insomnia where the complaint is difficulty in falling asleep. ii) Maintenance Insomnia in which after initial falling sleep, it is difficult to stay asleep or wakes up too early [2]. Other academic classification looks Insomnia as i) Primary Insomnia, where it is not linked to any other health condition ii) Comorbid / Secondary Insomnia in which there is some other medical or psychiatric conditions [2].

Behavioural insomnia of childhood: Behavioral insomnia of childhood (BIC) affects up to 30% percent of children. A general practitioner may identify three types; 1) BIC sleep-onset results from special conditions at bedtime, such as learning to go to sleep by being rocked or holding a toy close to chest or having a parent nearby as a child falls asleep ii) BIC limit-setting, involves a child's refusal to go to bed and repeated attempts to put off going to sleep by seeking attentions like asking for a drink, to go to the bathroom, or for a parent to read them a story or see a comic on the TV or mobile. Such child may refuse to go back to sleep even after they wake up iii) BIC combined type is a combination of sleep-onset & limit-setting BIC. BIC is usually resolved by creating a healthy sleep routine or learning self-soothing or relaxation techniques.

In a study of One hundred children (52 male & 48 female) a total of 19 (19%) children were found to have sleep disturbances. Among these children, 15 (15%) had bedtime resistance, 25 (25%) had sleep-onset delay, 15 (15%) had sleep deprivation, 9 (9%) had sleep anxiety, 30 (33.7) had night waking, 58 (59.2%) had parasomnias (bruxism, enuresis, nightmares, and night arousal), 21 (48.8) had sleep-disordered breathing, & 31 (31%) daytime sleepiness [9]. In the age group of 4–8 years, sleep disturbances were predominantly more in females compared to males. Among total sleep disturbances, the maximum disturbances were seen in the form of parasomnias, bedtime resistance leading to excessive daytime sleepiness [7].

In another a hospital based descriptive study among 1024 children visiting the paediatric outpatient departments of Madras medical college, Chennai and Al-Ameen medical college and hospital, Vijayapura over a period of 1 year from March 2022 to March 2023 reported Out of 1164 questionnaires, 1024 {88.97%, 497 (48.54%) boys & 527 (51.46%) girls0} were filled completely and returned. Of the 1024, 403 {(39.36%) 211 (52.36%) boys and 192 (47.64%) girls had one or more sleep related problem. Insomnia was more among boys than girls statistically significant at 5% level. Sleep disorders were predominantly found in the age group of 7-10 years among

which most common sleep related disorder was nocturnal enuresis and sleepwalking [8].

In another recent cross-sectional analytical study from January to April 2024 among 600 children aged 6–12 years enrolled in five urban private schools in Srinagar; the prevalence of clinically significant sleep disturbance was 42.3%. Mean daily screen-time was 3.1 ± 1.4 hours. Sleep disturbance showed a significant dose–response relationship with increasing screen exposure. Screen use within one hour of bedtime emerged as the strongest predictor, followed by daily screen-time exceeding three hours, smartphone gaming, bedroom device availability, and low parental monitoring [9].

Financial problems, Unemployment & Insomnia: Financial problems particularly among the unemployed and lower-income groups, are strongly associated with a high prevalence of insomnia' Financial dependency and debt contribute significantly to sleep disorders. Research highlights that economic stress, coupled with factors like age and lack of health insurance, severely impacts sleep quality [5].

Household financial hardship primarily affects the mental and physical health of children, with adolescence being a particularly vulnerable period for emotional and sleep-related issues. A study of the elderly in an urban health centre in India found a 64.9% prevalence of insomnia, strongly associated with financial dependency, being unemployed, and having stressful life events. High levels of sleep disorders (14%) are found among hundreds of my clients who are unemployed, and the problem gets resolved once they get a job and start earning. Financial stress and high cost of education have been identified as contributors to sleep disturbances among students in India, especially in private medical institutions. Heads of the families complain of chronic Insomnia due to that rising household debt and reliance on unsecured personal loans led by increased stress,

A community survey-based on interviewing more than 30,000 respondents across 13 markets, indicates that while sleep is increasingly recognised as essential to well-being, a significant gap remains between awareness and action. The survey found that nearly half (49%) of Indian respondents struggle to fall asleep at least three times a week. While one in two respondents said they would seek help immediately if they had sleep disturbances, most either postpone action or continue to live with poor sleep. Women are more likely than men to take proactive steps, with 58% seeking help compared to 41.92% of men [5]

Insomnia among elderly Population: In cross-sectional study conducted in a rural and an urban area of Delhi taking 115 participants from each area using systematic random sampling and using a semi-structured questionnaire for data collection. Out of 230 participants, 121 (52.6%) were females and 109 (47.4 %) were males. Insomnia was more prevalent in the elderly participants of rural area (95%) while just 5% were in the urban population, a statistically significant association with the locality of the participants (p-value <0.05). Out of the 230 participants, 113 (49.1%) had scores of 0-7 whereas 117 (50.9%) had scores between 8-28 which meant they had some degree of insomnia [6].

Diagnosis: A Primary health care provider must make a good analysis of the types, triggers of Insomnia using the program in annexure1. Then asses the home remedies already tried before planning individualised treatment plan. Despite its high prevalence, many individuals with insomnia do not seek or receive treatment. Acute insomnia often resolves, but if left untreated, it may become chronic, with a 27% relapse rate after treatment.

Management:

Home remedies for Insomnia: Every patient coming seeing help of family doctor would have tried one or more of the well-known seven effective home remedies These include i). Development of a Consistent Sleep Routine where the times of going to bed and waking up are the same for both weekdays and weekends, which regulates the internal clock, or the circadian rhythm, of our body ii) Having a Bedtime Ritual Soothing a warm bath or listening to soft music iii) Applying Herbal Remedies like valerian root, chamomile, and passionflower iv) creating a Sleep-Promoting Environment, Optimizing our bedroom for sleep will let us relax faster, take less time to fall asleep, and have a deep restorative sleep. Three key elements are temperature, lighting, noise, and comfort. Keep the bedroom cool and comfortable, aiming for a cooler room generally between 15-19°C that helps to allow our body to reduce its temperature and signal itself it's time to sleep. v) mindfulness and meditation, with their enormous potency for relieving all sorts of anxiety and depression, mindfulness and meditation improve our sleep quality. vi) Stress and Anxiety Management through routine physical activity-exercise works in the body to release endorphins; the natural chemical, which helps decrease the individual's level of anxiety & enhance moods viii) Dietary Changes for Enhanced Sleeping like enhancing use of Turkey which contains a lot of tryptophan, an amino acid that helps produce serotonin and melatonin, Bananas contain potassium and magnesium, minerals that relax muscles before sleep. Cherries, in turn, are a natural source of melatonin that helps the body fall asleep & stay asleep. On the other hand, avoiding consuming Caffeine, Nicotine, & alcohol which are popular sleep disruptors [10].

The 4-7-8 sleep method: Developed by Dr. Andrew Weil, it is rooted in the ancient yogic technique of pranayama, a rhythmic breathing technique designed to induce relaxation and sleep by calming the nervous system. It involves inhaling through the nose for 4 seconds, holding the breath for 7 seconds, and exhaling through the mouth for 8 seconds, repeated 3-4 times, it reduces stress and anxiety. General practitioner must train their patients by i) Good Positioning asking to lie down in bed or sitting on an easy chair with his/her back straight ii) Ask the client to place the tip of his/her tongue against the ridge of tissue behind their upper front teeth for the entire exercise iii) Ask them to empty their lungs of air completely through your mouth iv) Then ask to inhale for 4 seconds by closing the mouth and inhale quietly through the nose for a count of four v) then they are told to hold the breath for a count of seven(7 seconds). And vi) and exhale completely through his/her mouth with a "whoosh" sound for a count of eight (8 seconds) vii) Repeat such cycle 3-5 times. Regular practice twice a day makes the technique more effective over time. It works by increasing oxygen levels, slowing the heart rate, and reducing anxiety, which helps transition the body into a parasympathetic state (rest and digest). If initially holding the breath is difficult, the counts can be shortened (e.g., 2-3.5-4), or the overall speed of the cycle can be increased. The repetitive nature of 4-7-8 breathing provides a calming distraction to our racing mind. The counting sequence is a way to focus our mind on something other than our worries or concerns of the day [10].

If these approaches do not work or if sleeplessness interferes with daily life for more than a few weeks, the primary healthcare providers must encourage their clients and families to seek care, to identify the cause and better management.

Non-Pharmacological Management of Insomnia: Non-Pharmacological management include Cognitive Behavioural Therapy for Insomnia through education, stimulus control, sleep restriction, and cognitive restructuring as the first-line treatment. Stimulus Control techniques like using the bed only for sleep and intimacy, leaving the bed if unable to sleep within 15-20 minutes, and maintaining a strict sleep & wake-up time. Limiting time in bed to actual sleep time increases sleep efficiency.

Pharmacological Management: Pharmacotherapy for insomnia is common, is used for short-term management or if CBT-I is ineffective and hypnotic agents are among the frequently prescribed medications in India. Older medications for insomnia are limited by their side effect burden and

narrow therapeutic window. Newer hypnotics, on the other hand, have been shown to have a better safety profile and longer-term efficacy. The decision to treat chronic insomnia disorder with long-term hypnotics should be individualized and balance the potential risks of continuing hypnotic medication use with the risks of untreated persistent insomnia and associated functional limitations [13]. A 2020 report notes that 80% of consultations for elderly insomnia resulted in prescriptions, often Z-hypnotics or benzodiazepines, despite high risk of side effects. This points to a need for non-pharmacological approaches like Cognitive Behavioural Therapy for Insomnia (CBTI)

A) Non-benzodiazepine Hypnotics like Zaleplon (Zonesta & Zaplon), zolpidem (Zolfresh & Nitrest), and eszopiclone (Fulnite & Hypnite) are frequently used for sleep initiation. There are many more such commercial products in Indian market.

B) Melatonin Agonists (Meloset, Noctura, Altonil), are used for sleep onset difficulties. Dual Orexin Receptor Antagonists (DORAs) like Suvorexant, lemborexant, and daridorexant are approved for treating chronic insomnia. Sedating Antidepressants like Doxepin is used for sleep maintenance.

C) General Advice & Hygiene: Maintaining a regular sleep schedule, even on weekends, avoiding caffeine, alcohol, and heavy meals close to bedtime and creating a quiet, dark, and comfortable sleep environment also play key role in avoiding Insomnia [12,13]

Integrated Treatment: For patients with comorbid psychiatric/medical conditions, treating the insomnia concurrently with the other condition yields better outcome

A multicentre, cross-sectional survey was administered to 1,770 elderly primary care patients from 71 government primary health centres in Kerala, India, from May to December 2016. Insomnia was evaluated using the Insomnia Severity Index. Study instruments included the Patient Health Questionnaire-Somatic, Anxiety, and Depression Symptoms; Alcohol Use Disorders Identification Test; Fagerström Test for Nicotine Dependence; 12-item World Health Organization Disability Assessment Schedule; and World Health Organization Quality of Life-BREF. Among valid responses of 1,574 (89%) patients, the mean age was 68.6 years men and 55.5% were women. Clinical insomnia was reported by 11.8%, whereas 30.4% had subclinical insomnia. Primary care attendees with subclinical as well as clinical insomnia had increased odds of being older and female and having chronic medical illness compared with those without insomnia. Patients with clinical insomnia had increased odds of common mental disorders like anxiety, depression, and somatization and greater disability compared with the subclinical or no insomnia groups. Those with subclinical insomnia had poor satisfaction with life compared to those with no insomnia [14].

A 2025 study of 380 hospital nurses found a 56.1% prevalence of insomnia, with stress and burnout acting as direct, strong drivers, particularly among those with shift patterns or high emotional demands. A study on night-shift workers (2014-2018 data) found that those working over 40 hours per week had roughly two-fold higher odds of insomnia. Insomnia may be primary or secondary, and can be transient, short-term, or chronic. Common clinical subtypes include psychophysiological insomnia, paradoxical (sleep state misperception), idiopathic insomnia, poor sleep hygiene, and behavioural insomnia of childhood. Chronic insomnia is frequently linked to stress, irregular schedules, medical illnesses, mental health disorders, and aging-related factors such as nocturia, pain, inactivity, and polypharmacy. Evaluation in smaller settings should focus on careful history-taking, identification of red flags such as obstructive sleep apnoea, and use of simple tools like sleep questionnaires or activity tracking when available. Snoring, daytime sleepiness, morning headaches, and fatigue should prompt consideration of sleep apnoea. Management should prioritize non-pharmacological approaches, including sleep hygiene education, relaxation techniques, stimulus control, and cognitive behavioural therapy for insomnia (CBT-I). Sleep Restriction Therapy, a component of CBT-I, helps reset sleep drive and reduce anxiety around sleep. Medications may be used selectively and short-term, with caution in children and the elderly. With structured assessment and emphasis on behavioural strategies, insomnia can be effectively managed even in resource-limited or smaller clinical settings, improving overall health and quality of life.

Conclusion:

Insomnia is increasingly common across all healthcare settings, including smaller clinics and primary care practices. Sleep is a vital biological process, with Stage 3 non-REM (deep) sleep plays a key role in brain restoration, healing, and metabolic balance. Digital screen exposure is strongly and independently associated with sleep disturbances among school-aged children, remotely working class and IT software professional. Targeted interventions focusing on evening screen restriction, reduced screen duration, and improved parental monitoring may substantially improve paediatric sleep health. An understanding of the physiology of sleep is critical to a paediatrician and primary care physician's ability to effectively and confidently counsel patients about sleep. Improving deep sleep can often be achieved through simple, practical measures such as regular physical activity, adequate fibre intake, avoiding caffeine and alcohol near bedtime, maintaining consistent sleep timing, and creating a calm, sleep-friendly environment. Treatments for bedtime problems & night waking are efficacious and durable. Pharmacotherapy for insomnia has a role for short-term management or if CBT-I is ineffective and hypnotic agents are among the frequently prescribed medications in India. The decision to treat chronic insomnia disorder with long-term hypnotics should be individualized and balance the potential risks of continuing hypnotic medication use with the risks of untreated persistent insomnia and associated functional limitations

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Annexure-1

Proforma For Assesing Sleep Disorders in Children

Name: Age: Sex: Informant:

Family Demography:

(Working Hrs)

Symptoms

Medical history (Yes/No)

GERD: Infantile colic:

Snoring: Never / Occasional / < 3 / > 3 Per Week

Choking: Snort: Arousal: Fragmented sleep: Mouth Breathing: Swallowing defect: Drooling:

Prematurity: Genetic Disease: Neuromuscular disease: Cognitive Anomaly: Others:

Sleep diary/BEARS sleep screen (Yes/No)

B (bedtime problems):

E (excessive day time sleepiness):

A (awakening at night):

R (regularity & duration):

S (snore):

Night awakenings

No: Yes (duration/ WASO/ longest stretch of arousal):

Associations: Positive (patting/ holding/ allow to cry/ shushing (positive):

Negative (picking up/ feeding/playing with smart screen/ walking around/rocking/cradle):

Bedtime routine: Feeding/brush/cuddle/ night clothes/ massage/ pacifier/ songs/ books/ bath/tv/ prayers/others:

Sleep environment

Co-sleep/ separate room/sibling's/ cradle:

Supine/ prone/side:

Light: dark/ bed lamp/ lights

Sound: nil/ music/ loud sound

Care giver: mother/ father/ care giver

Examination

Weight: height/length: head circumference:

HR: RR: BP: SpO2:

Dysmorphism: genetic: neuromuscular:

ENT Exam: Nose/ Ears Tonsil Score Mamilla Pati Score

Palate Uvula Mandible

Systemic examination:

Respiratory CVS

Neurological others

Provisional Diagnosis:

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