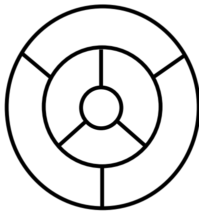


Rocky Garrison, PhD, CBSM
Clinical Psychologist
rockygarrison.com
2104 NE 45th Avenue
Portland, OR 97213
503-317-4521
fax: 503-282-0616

CONFIDENTIAL CLINICAL RECORD

NAME: Overview Case DOB:

IDENTIFYING INFORMATION: Overview Case was a 58 year old married woman who was referred for assessment and treatment of insomnia by A. Referring Physician. She reported ethnic heritage as irish and Belgian.

Goals identified for insomnia treatment by this client were acquiring techniques to help her sleep better.

CURRENT MEDICATIONS: Lisinopril, 40 mg; Acyclovir, 400 mg;

SLEEP AIDS: Trazodone 50 mg (started recently and used about half the time with not much effect)

TREATMENT HISTORY: has taken diphenhydramine 50 mg; she uses a light box in the winter

INSOMNIA COMPLAINT: Overview reported a severe difficulty falling asleep, moderate difficulty staying asleep, and mild problems waking up too early. Noise, temperature, caffeine and sweets were identified as worsening sleep; sleeping alone, ambient noise, and a night light were identified as improving sleep. Sleep in a different bed or location was described as worse. On the Insomnia Severity Index obtained a score of 16, indicating moderate clinical insomnia.

CURRENT SLEEP QUALITY: Overview reported a usual bed time of between 10:30 PM and midnight, and a usual rising time of between 6:30 and 7:30 AM. Total sleep time is estimated to be 5 to 6 hours. Sleep latency is over 30 minutes; sleep efficiency is 70%. On the Pittsburgh Sleep Quality Index she obtained a score of 13 on the Global Scale, 4 on the Sleep Efficiency Scale, 6 on the Perceived Sleep Quality Scale, and 3 on the Daily Disturbances Scale. These scores indicate poor sleep quality.

SLEEP HABITS: Prior to bed Overview does some gentle stretching and has a snack. Once in bed she reads, does crosswords, and listens to relaxing music. She noted that she has no set schedule and considerable variability in her sleep schedule. Naps occur once a week for 1 to 1½ hrs; involuntary daytime sleep episodes are denied. Sleep was described as nonrestorative. Chronotype is identified as a morning person. Spring and Fall are worse times for her for sleeping. On the Pre-Sleep Arousal scale she obtained a score of 15 on the Somatic Domain and 30 on the Cognitive Domain, indicating a moderate level of somatic pre-sleep arousal and a high level of cognitive pre-sleep arousal.

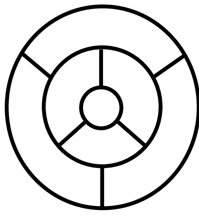
SLEEP HISTORY: Overview recalls having a fear of going to sleep when she was 10 or 11 years old, when she was afraid of dying. Her sleep was poor through her college years living in a dorm. Sleep improved for about 20 years, then in her early 40's she gradually began having more difficulty getting to sleep and with nonrestorative sleep. Sleep further worsened at menopause.

BEDROOM ENVIRONMENT: Bed is in good condition. Bedroom is quiet and dark. A clock is visible from sleep position. She sleeps in a separate room from her husband because of his snoring.

NOCTURNAL SYMPTOMS: Snoring, gasping and coughing are denied. STOP-BANG score is 3/7. RLS symptoms are endorsed on some nights. She also has similar symptoms in her arms less than once a week. Bruxism is present on some nights. Most of her awakenings are spontaneous.

DAYTIME FUNCTIONING: Overview is currently a student, off for the summer. She is studying inhalation therapy and is set to do an internship this fall. On the Sleep Related Behaviours Scale she identified a number of cognitive behaviors, such as worry and apprehension, that she employs to cope with tiredness during the day. On the Flinders Fatigue Scale she obtained a score of 14, indicating above average fatigue compared to a sample of poor sleepers.

PSYCHOLOGICAL FUNCTIONING: Overview described her mood as “positive,” energy level as “good,” and appetite as “no problem.” She denied anhedonia. Average score on the 4 item positive affect scale was 5.0, indicating an above average level of positive affect. She denied feelings of worthlessness,



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hopelessness, and guilt, compulsions and avoidances. She acknowledged anxiety and worry, slight claustrophobia, and a few panic attacks about 4 years ago. History of psychological trauma was denied. Score on the Arousal Predisposition Scale was 29, placing her at the 10th percentile. On the Kessler Psychological Distress Scale she scored 16, indicating a low level of psychological distress.

CURRENT STRESSORS: worry about upcoming internship and work, husband's health (he has severe heart disease), son's future

FAMILY HISTORY: positive for insomnia, anxiety and depression; negative for sleep walking, substance abuse, and psychiatric hospitalization

HABITS: alcohol, tobacco, drug use, and coffee are denied. Overview walks about 3 miles 4 times a week and regularly prays.

ASSESSMENT: Overview has had intermittent sleep difficulties throughout her life. She has a great deal of variability in her sleep schedule from day to day and naps about once a week. Sleep efficiency is low. She has a high level of apprehensive worry about sleep and a variety of other topics.

DIAGNOSIS: psychophysiological insomnia

PLAN: Overview will adopt a more consistent sleep schedule with 6½ to 7 hours of sleep opportunity. She will use a relaxation CD to acquire a relaxation response. She will keep a worry diary to identify worries for disputation. She will increase her awareness of when she uses hypothetical, "what if?" logic.

RTC: 3 weeks later

Rocky Garrison, Ph.D., CBSM
OR Psychologist #503